NHS
East Lancashire Hospitals
NHS Trust
A University Teaching Trust

East Lancashire Hospitals NHS Trust Board Meeting

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East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD (OPEN SESSION) AGENDA

14 January 2026 at 09.30

Boardroom, Trust Headquarters, Royal Blackburn Teaching Hospital

✓ = document attached
v = verbal

Time	Ref	Item	Lead		Purpose
OPENING BUSINESS					
09.30	TB/2026/001	**Chairs Welcome and Apologies for Absence**	Chair	v	Information
09.32	TB/2026/002	**Declarations of Interests**	Chair	v	Information
09.35	TB/2026/003	**Minutes of the Previous Meeting**	Chair	✓	Approve
09.40	TB/2026/004	**Action Tracker and Matters Arising**	Chair	✓	Discussion
09.50	TB/2026/005	**Patient Story**	Chief Nurse	v	Information
10.00	TB/2026/006	**Chair's Report**	Chair	✓	Information
10.05	TB/2026/007	**Chief Executive's Report**	Chief Executive	✓	Information
FORMULATING STRATEGY					
10.25	TB/2026/008	**Provider Collaboration Board Strategic Update**	Chief Executive	✓	Information
ENSURING ACCOUNTABILITY					
10.40	TB/2026/009	**Financial Performance Report – Month 8**	Executive Director of Finance	✓	Assurance
11.00	TB/2026/010	**Integrated Performance Report**	Executive Directors	✓	Assurance
11.20	TB/2026/011	**East Lancashire Hospitals NHS Trust Improvement Plan**	Dir. of Service Imp.	✓	Assurance
COMFORT BREAK 11.35 – 11.45					
11.45	TB/2026/012	**Maternity and Neonatal Services Update**	Chief Nurse/Executive Medical Director	✓	Assurance
12.00	TB/2026/013	**Patient Safety Incident Response Assurance Report**	Executive Medical Director	✓	Assurance
GOVERNANCE					
12.05	TB/2026/014	**Corporate Risk Register Report** *Deferred*	Ass Dir of Health, Safety and Risk	d	Assurance
12.15	TB/2026/015	**Board Assurance Framework**	Interim Dir. of Corporate Governance	✓	Assurance

12.25	TB/2026/016	**Education Research and Innovation Committee Terms of Reference**	Interim Dir. of Corporate Governance	✓	Approval
ITEMS FOR NOTING					
---	TB/2026/017	**Risk Management Strategy**	Executive Medical Director	✓	Assurance
---	TB/2026/018	**Triple A Reports from Quality Committee** a) November 2025 b) December 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2026/019	**Triple A Reports from Finance & Performance Committee** a) November 2025 b) December 2025	Committee Chair	 ✓ ✓	Assurance
---	TB/2026/020	**Triple A Reports from People & Culture Committee** a) December 2025	Committee Chair	 ✓	Assurance
---	TB/2026/021	**Triple A Report from Audit and Risk Committee** a) November 2025	Committee Chair	 ✓	Assurance
---	TB/2026/022	**Triple A Report from Trust Charitable Funds Committee** a) December 2025	Committee Chair	 ✓	Assurance
CLOSING MATTERS					
12.30	TB/2026/024	**Message from the Board**	Chair	v	Information
12.35	TB/2026/025	**Any Other Business**	Chair	v	Information
	TB/2026/026	**Date and Time of Next Meeting** 11 March 2026 at 9.30am, Boardroom, Trust HQ	Chair	v	Information

BOARD MEETING (PUBLIC SESSION)

12 November 2025 9.30AM

BOARDROOM, TRUST HQ

MINUTES

PRESENT

Mr S Sarwar	Chairman
Professor G Baldwin	Non-Executive Director
Mr S Featherstone	Non-Executive Director
Dr J Hobbs	Executive Medical Director
Mr M Hodgson	Chief Executive
Mrs S Gilligan	Chief Operating Officer / Deputy Chief Executive
Mrs C Randall	Non-Executive Director
Mr K Rehman	Non-Executive Director
Mrs L Sedgley	Non-Executive Director
Mrs S Simpson	Executive Director of Finance

BOARD MEMBERS IN ATTENDANCE (NON-VOTING)

Mrs K Atkinson	Executive Director of Service Development and Improvement
Professor S Bari	Associate Non-Executive Director
Mrs M Hatch	Associate Non-Executive Director
Mr T McDonald	Executive Director of Integrated Care, Partnerships and Resilience
Mr N Pease	Interim Chief People Officer
Miss S Wright	Executive Director of Communications and Engagement

IN ATTENDANCE

Dr A Brown	Intensive Improvement Director, National Recovery Support Team – Chief Operating Officer's Directorate	Observer
Mr D Byrne	Corporate Governance Officer	Minutes
Mrs C Carter-Jones	Deputy Director, National Recovery Support Team	Observer
Mrs S Giles	Interim Director of Corporate Governance / Company Secretary	
Mr M Maher	Clinical Director, Obstetrics and Gynaecology	Item: TB/2025/153
Mrs J Pemberton	Deputy Chief Nurse	For Mr Murphy

Mr B Spencer	Public Governor, Lancashire and South Cumbria NHS Foundation Trust	Observer
Miss T Thompson	Divisional Director of Midwifery and Nursing	Item: TB/2025/153

APOLOGIES

Mrs S Bridgen	Non-Executive Director
Mrs A Bosnjak-Szekeres	Director of Corporate Governance / Company Secretary
Mr P Murphy	Chief Nurse

	23 Apr 2025	14 May 2025	9 Jul 2025	10 Sept 2025	12 Nov 2025	14 Jan 2026	11 Mar 2026
Mr S Sawar	✓	✓	✓	✓	✓		
Mrs S Bridgen	✓	✓	✓	A	A		
Mrs T Anderson	A	✓					
Prof G Baldwin	A	✓	A	A	✓		
Mrs C Randall	A	✓	A	✓	✓		
Mr K Rehman	✓	✓	✓	✓	✓		
Mrs L Sedgley	✓	✓	✓	✓	✓		
Mrs M Hatch	✓	✓	✓	✓	✓		
Dr S Bari			✓	✓	✓		
Mr S Featherston			✓	✓	✓		
Dr J Hobbs				✓	✓		
Mr M Hodgson	✓	✓	✓	✓	✓		
Mrs S Simpson	✓	✓	✓	D	✓		
Mrs S Gilligan	✓	✓	✓	✓	✓		
Mr P Murphy	✓	✓	✓	✓	D		
Mrs K Quinn	A	A					
Mr M Ireland	✓	✓					
Mrs K Atkinson	✓	✓	D	✓	✓		
Mr T McDonald	✓	D	✓	D	✓		
Miss S Wright	✓	✓	✓	✓	✓		
Mr S Islam	✓	✓	✓				
Mr N Pease			✓	✓	✓		

✓ Attended **A apologies** **D Deputy attended**

TB/2025/138 CHAIRMAN'S WELCOME AND APOLOGIES

Directors and observers were welcomed to the meeting. Apologies were recorded as above.

TB/2025/139 DECLARATIONS OF INTEREST

There were no additional declarations of interest raised.

TB/2025/140 MINUTES OF THE PREVIOUS MEETING

Mrs Sedgley recalled that Mrs Bridgen had been present at the previous meeting of the board and requested that the minutes were amended to reflect this.

Directors otherwise approved the minutes of the previous meeting held on the 10 September, and the minutes of the extraordinary meetings of the board held on the 29 September and 13 October, as true and accurate records.

The minutes of the meetings held on 10 September, 29 September and 13 October 2025 were approved as true and accurate records, pending the requested amendment.

TB/2025/141 ACTION TRACKER AND MATTERS ARISING

Directors noted that all items on the action matrix were reported as complete, had been updated via the action matrix report or were to be presented as agenda items at this, or at subsequent meetings. The following updates were provided:

Patient Story – It was agreed that this action be transferred to the Quality Committee for ongoing oversight rather than being left open indefinitely. It was acknowledged that it remained challenging to persuade patients to attend board meetings to present their stories and the board discussed considering involving patient advocacy organisations to support patients in sharing their experiences. The need for patient perspectives to be a consistent theme in strategic discussions at the Trust going forward was highlighted.

Directors noted the position of the action matrix.

TB/2025/142 PATIENT STORY

Directors were referred to the patient story which highlighted the importance of effective communication within the Trust. The patient story can be viewed here.

The patient story was recognised as a strong example of Safe, Personal and Effective (SPE) care, and provided valuable insights into quality and safety aspects. The board acknowledged that, despite significant financial challenges, the Ear, Nose and Throat (ENT) specialty continued to demonstrate high productivity and efficiency, currently being among the best in the country for theatre utilisation.

Directors discussed the potential for sharing patient stories more widely across the organisation, including through the Trust intranet and other communication channels, provided that those involved were comfortable with this approach. It was agreed that sharing both positive and less favourable experiences would be beneficial for organisational learning and improvement. The importance of balancing positive and negative patient experiences was emphasised, and it was noted that several positive stories had been shared of late.

Directors received the Patient Story and noted its content.

TB/2025/143 CHAIR'S REPORT

Directors received an overview of Mr Sarwar's activities since the previous meeting.

The board was informed that the Trust's application for university hospital status had been submitted. The chair expressed gratitude to those involved in this process. It was highlighted that achieving university status would raise the profile of the organisation and attract new talent to the Trust.

Directors were reminded of an upcoming review concerning antisemitism. The positive steps being taken within the Trust regarding its adoption of an anti-racism approach were outlined and it was suggested that these efforts and progress should be communicated more widely throughout the organisation to reflect ongoing commitment.

It was noted that this was Mr Sarwar's last meeting as chair. He expressed pride in the achievements made in system and performance during his tenure, while acknowledging ongoing financial challenges and the need to address resource inequities. Mr Sarwar expressed confidence in the Trust's ability to return to a balanced position and extended his thanks all colleagues for their support.

Directors also noted that the meeting would be Mrs Hatch's last in her role as an associate non-executive director. Emphasis was put on Mrs Hatch's significant contributions to addressing health inequalities and her key role in reviewing the charitable funds committee to strengthen its effectiveness.

Directors received and noted the report provided by the chair.

TB/2025/144 CHIEF EXECUTIVE'S REPORT

Directors received a summary of national, regional and Trust specific headlines since the previous meeting.

At a national level, updates were provided on the establishment of a joint executive team across the Department of Health and Social Care (DHSC) and NHS England (NHSE), the publication of the NHS medium-term planning framework, the publication of NHS 'league tables', the announcement of a rapid investigation into maternity and neonatal services at 14 trusts, an urgent review of antisemitism and all other forms of racism in the NHS, further industrial action and the implementation of the new NHS Online service.

At a regional level, updates were provided on senior staffing changes at Integrated Care Board level, the selection of Blackburn with Darwen (BwD) as one of 43 pilot areas for the Neighbourhood Health Implementation Programme, the implementation of a groundbreaking online service to give patients greater control over their appointments, new grants to boost cancer awareness and early diagnosis, the winter flu and COVID-19 vaccination campaigns across Lancashire and South Cumbria (LSC) and the introduction of new services to improve the lives of those living with dementia.

At a Trust level, updates were provided on changes to the Trust Board, the Medical Directorate, the Trust's financial recovery plan, the outcomes of a recent mid-year review by NHSE, a recent meeting between LSC chief executives to discuss the future of One LSC, ongoing work around the Accrington Victoria community Hospital (AVCH) site, the launch of the current year's National NHS Staff Survey, and the awarding of UNICEF Baby Friendly Initiative (BFI) Stage One accreditation for the Trust's Paediatric Services.

The board discussed the delivery of the ten-year health plan, with particular emphasis on the shift from hospital-based to home-based care. It was highlighted that the Trust operated strong community services and that the Neighbourhood Health Implementation Programme would present additional opportunities to work with partners to deliver more integrated care outside hospital settings.

Directors were advised that of the 14 investigations announced into maternity and early obstetric services, two would be taking place at local organisations. It was highlighted that the Trust's maternity services continued to operate at a high standard, with a strong ongoing focus on providing inclusive and positive care to the most vulnerable in society.

Directors acknowledged the recent publication of national NHS league tables. It was agreed that the Trust was recognised as a good system player and was currently providing support to other trusts in the region on certain performance targets. It was also noted that the recently published indices of multiple deprivation for 2025, highlighting health inequalities and access to services, had clearly indicated that BwD and Burnley were challenged areas.

The board went on to recognise the right of colleagues to participate in industrial action, while noting the additional challenges this posed in delivering patient care. It was reported that the next round of industrial action was anticipated in the following week and that the Trust would aim to maintain 95% of routine activity, acknowledging that this target would be challenging and not without cost. It was emphasised that the Trust remained extremely busy, with an increase of 79 patients per day through urgent and emergency care (UEC) pathways compared to the previous year yet continued to demonstrate robust productivity and efficiency.

Directors were advised that every NHS organisation was expected to nominate a lead official as part of the national Infected Blood Inquiry and that Dr Hobbs would be taking on this role for the Trust.

The board went on to discuss the Trust's financial situation, noting that while good progress had been made, significant challenges remained. It was highlighted that there had been substantial reductions in the pay bill but that further work was required to deliver efficiency schemes. The recent mid-year review with NHS England was reported as being largely positive, with clear recognition of the Trust's performance and emphasis on maintaining quality. Directors noted the Trust's recent transition from host to lead provider for One LSC, and that work was ongoing to determine the associated practical implications.

Mr Sarwar informed directors that, following his departure from the Trust in December, the role of chair would be filled on an interim basis by Professor Mike Thomas, currently the chair at Lancashire Teaching Hospitals NHS Foundation Trust.

Directors received the report and noted its contents.

TB/2025/145 PROVIDER COLLABORATION BOARD STRATEGIC UPDATE

Directors received a summary of discussions from the Provider Collaborative Board (PCB) meetings held on 11 September and 9 October 2025. It was noted that all organisations across LSC continued to face significant challenges in both performance and financial domains and

that the Trust continued to perform relatively well, particularly in terms of performance metrics. It was highlighted that work was ongoing to develop a more affordable and resilient acute clinical configuration across LSC and that initiatives included the transition to a single service for pathology and vascular. Directors noted that at the October meeting of the PCB, a presentation was delivered on the development of new clinical standards, particularly concerning high numbers of days spent in neonatal units, the care of low-weight babies, and the configuration of level two and three neonatal units. There was agreement on the need to continue working with specialist commissioners on the development of options in this area going forward.

Directors received the report and noted its contents.

TB/2025/146 TRUST STRATEGY REFRESH – PROGRESS & NEXT STEPS

The board received an update on the ongoing process to refresh the Trust's strategies. It was reported that all existing strategies would be consolidated into a single, overarching strategy document, supported by a range of key enabling plans. It was confirmed that consideration had been given to new data on population indices and deprivation when shaping these strategies, and that they must continue to be responsive to the needs of the local population. The latest NHS 10-Year Plan was identified as a significant factor influencing strategic thinking, alongside place-based plans and ambitions for specialist and complex services. Directors were advised that a series of engagement activities had commenced, with the intention of collating feedback into key themes for further discussion at strategic sessions and future board meetings and that the planning process was expected to continue into the new year. It was acknowledged that there were several risks associated with delivering this work alongside existing activities, particularly in terms of organisational capacity.

In response to queries raised regarding stakeholder engagement, it was confirmed that a questionnaire had been designed for staff to be distributed through divisional structures, along with a series of additional meetings scheduled with staff. It was also confirmed that engagement with patients had taken place through the Trust's Patient Participation Panel (PPP), and that relevant information was being shared via other stakeholder websites. Directors noted that a variety of mechanisms were being employed to maximise feedback, with efforts made to keep questions simple and accessible.

Directors noted the update provided.

TB/2025/147 FINANCIAL REPORT

Directors received an overview of the Trust's financial performance as of month six (M6), which highlighted the following key points:

- The Trust was reporting a deficit of £5.34m as of M6, £1.8m behind its planned target of £3.54m.
- The year-to-date (YTD) deficit stood at £35.2m, which was £7.3m behind the planned position of £28m.
- In month, the Trust's Waste Reduction programme (WRP) delivered £2.9m against the WRP Delivery plan, £1.8m adverse to its reprofiled plan. YTD WRP delivery was reported at £18.4m, £3m behind the reprofiled plan.
- The Trust's cash balance stood at £13m as of the end of September, an increase of £2.4m compared to M5 cash position of £10.6m.
- The Trust's Capital Plan spend was reported at £12.7m as of M6, £2.5m ahead of plan.

Directors discussed the operational pressures outlined in the report, including the impact of initiatives that did not come with additional funding, and the drivers of other financial pressures. It was noted that good progress had been made in continuing to reduce bank and agency costs, with a sizable reduction in worked Whole-Time Equivalent (WTE) numbers observed from the end of the previous year to M6. It was acknowledged that the Trust's deficit position was continuing to drive a shortfall in cash and that further work would be needed with commissioning colleagues to ensure that the organisation was appropriately remunerated for the levels of activity that it was being expected to deliver.

The board went on to consider what mitigations would be required should additional support be needed later in the year around its cash position. The timing and implications of extending payment terms to suppliers were also discussed and it was confirmed that while payments might need to be stretched, suppliers would continue to be paid appropriately. It was emphasised that careful management of the Trust's run rate and cost reduction would be essential to support its cash position, which would be partially achieved through an increased focus on non-pay expenditure.

In response to queries raised around capital spend, it was confirmed that depreciation of new assets was a factor that would need to be carefully balanced when considering capital bids. It was explained that changes were expected to the organisation of capital 2026–27, though further clarity was still awaited around these.

The board reaffirmed its commitment not to reduce staffing costs in a way that could endanger patients, communities, or staff. It was confirmed that this commitment had been publicly reiterated at the most recent Improvement and Assurance Group (IAG).

Following further discussion, there was broad agreement on the need to accelerate the Trust's WRP to ensure eligibility for the Delivery Support Funding (DSF). There was also agreement on the need to implement robust governance arrangements to facilitate appropriate scrutiny and delivery and on the importance of rigorous and efficient management of expenditure and run rate. It was acknowledged that this would necessitate difficult discussions over the coming months.

Directors noted the financial report.

TB/2025/148 INTEGRATED PERFORMANCE REPORT (IPR)

a) Safe

Directors were referred to the safe section of the report and were advised that there were no areas of concern requiring escalation to the Board.

b) Caring

Directors were referred to the nursing fill rate information in the report and were advised that there were no areas of concern.

Responding to queries around reductions in the fill rates for night duty coverage, it was confirmed that this had been done to address pressures in the ED and to cover vacancies and that daily meetings were taking place to monitor this and record any red flags appropriately.

c) Effective

Directors were informed that the implementation of a checklist on the Cerner system had successfully supported recovery of the Trust's Venous Thromboembolysm (VTE) position and that further actions were being taken to support assessments in the ED. The Trust's mortality position was highlighted, with all metrics moving in a positive direction, though it was acknowledged further improvement was required.

Responding to queries on the commentary in the report around Structured Judgement Reviews (SJRs), it was explained that this was a capacity issue and that the matter was being actively addressed through restructuring of existing teams.

Directors were advised that queries had been raised around the volume of stillbirths at the Trust at the most recent meeting of the Finance and Performance Committee and that it was expected for a further update to be provided on this at the next meeting of the board.

ACTION: An update on the numbers of stillbirths in the Trust will be provided at the next meeting.

WHEN: January 2026.

WHO: Divisional Director of Midwifery and Nursing

d) Responsive

Directors received a summary of the Trust's most recently updated performance figures, it was noted that while the majority of performance metrics were on track or exceeding targets, significant concern remained around the volume of patients waiting for 12 hours or more in the Emergency Department (ED). Directors were informed that it was expected that a clear and sustained improvement would be seen in this area from December onwards once new arrangements were put in place to promote better management of patients.

It was confirmed that the Trust continued to deliver against its agreed trajectory for 52-week patients and that while performance against the Faster Diagnosis Standard (FDS) had dipped over recent months due to a range of factors including histopathology pressures and sickness and absence in key roles, a recovery plan was now in place to address this.

e) Well-led

It was reported that vacancies and bank usage had increased, while agency use remained at an all-time low. It was confirmed that a robust vacancy management system was in place, and it was expected that bank usage would decrease soon. It was also confirmed that clear trajectories and milestones around sickness and absence management would be taken to future meetings of the People and Culture Committee (PCC).

Directors noted that positive progress had been made around in flu vaccination uptake, with 32.3% of frontline staff now vaccinated.

In response to queries raised around when the Trust was expecting to reach 100% compliance with regard to consultant job planning, it was confirmed that team job planning was now open, with individual job planning scheduled to commence in January for a period of two months. It was highlighted that panels would be convened to ensure equitable agreements across divisions and the organisation as a whole. The board was advised that the national target was

to deliver 95% of agreed job plans and that it was planned was to achieve full delivery of this by the end of the current financial year.

Directors noted the Integrated Performance Report and received assurance about the activity being taken to improve and maintain performance.

TB/2025/149 EAST LANCASHIRE HOSPITALS NHS TRUST IMPROVEMENT PLAN (RSP EXIT CRITERIA)

The board received an update on the Recovery Support Programme (RSP) and the associated exit criteria for the Trust.

Progress against the exit criteria was outlined in the report, and it was confirmed that updates would be presented at each board meeting going forward. Directors were informed that at the time of reporting, most actions were rated as amber and that a comprehensive Governance and Leadership action plan was in place, with fifty-three of eighty-eight actions currently completed.

Responding to concerns regarding the plausibility of the Trust's financial recovery goals, it was acknowledged that while delivering £60.8m in efficiencies was a significant challenge, the Trust able to demonstrate that clear actions were being taken to meet this target. It was highlighted that the establishment of the Trust's Project Management Office (PMO) would help to increase the pace of the Trust's Cost improvement Programmes (CIPs) over the coming months and develop mitigations to facilitate the delivery of the Trust's financial plan for the year. Directors were informed that a rolling programme of deep dives into the cross-cutting workstreams had been mapped out for upcoming board committee meetings to provide additional assurance.

Following further discussion, the board expressed the aspiration to exit the RSP by March 2026, subject to meeting the agreed targets. It was acknowledged that there were cultural issues still to address to achieve this, which would be explored further through the Trust's governance processes.

Directors received the report and noted its contents.

TB/2025/150 PROVIDER CAPABILITY SELF-ASSESSMENT

Directors received an update on the Trust's provider capability self-assessment process. It was reported that a detailed assessment had been undertaken against the relevant Key Lines of Enquiry (KLOEs) within each domain and that the purpose of this exercise was to enasble

the Board to complete the self-assessment statement for submission to NHS England (NHSE). It was confirmed that the self-assessment process would become an annual process, with the expectation that the document would remain live and subject to ongoing review over time, with the current iteration due to be submitted by the end of the day.

The board went on to discuss the importance of integrating the self-assessment into existing governance arrangements. Mrs Giles explained that following the submission of the self-assessment, NHSE's assessment team would review the submission and in due course the Trust would be informed of their provider capability rating.

Directors received and approved the contents of the report for submission to NHS England.

TB/2025/151 FREEDOM TO SPEAK UP REPORT

Mrs Butcher joined the meeting for this item.

The Board received the Freedom to Speak Up (FTSU) report, which covered an eighteen-month period due to alignment issues between reporting at the People and Culture Committee (PCC) and the Board. It was noted that there had been a significant increase in the volume of concerns raised, with particular attention given to the growing number of Black, Asian and Minority Ethnic (BAME) colleagues choosing to speak up. It was highlighted that the scope of monitoring had been widened to capture more protected characteristics through the introduction of 'listening lab' and 'safe space' events.

It was noted that there had been a 33% increase in speaking up cases since 2024-25, and that this could be attributed to a range of factors, including improved training compliance and the training of an additional twenty-two FTSU ambassadors. It was pointed out that, while the increase in concerns might initially be alarming, it should ultimately be considered as a positive, as it indicated that colleagues felt comfortable raising issues. It was acknowledged that this increase had also raised further questions that would need to be addressed in the future.

Directors went on to discuss the importance of having open-door policies for sensitive issues, including concerns about board members. It was confirmed that colleagues had access to executive leaders and external reporting mechanisms if required. The need to handle issues arising from changes in posts with sensitivity was also emphasised and it was highlighted that a feedback form system was in place to follow up with individuals who had raised concerns.

Responding to queries regarding the planned transfer of FTSU services to NHSE outlined in the report, it was advised that no local disruption was expected, with the only significant changes likely being around reporting arrangements.

The board went on to consider how best to support the workforce when raising concerns through the FTSU service. Openness and transparency regarding discrimination were discussed and it was noted, with disappointment, that discrimination remained among the top three reasons for concerns raised. Directors acknowledged that some issues in the report, particularly those relating to sexual misconduct, required further consideration by the PCC. Issues relating to racism and the Lord Mann review into antisemitism and other racism across the health and care sector were also discussed. It was confirmed that work was ongoing around the Trust's Aarushi Project and that action plans continued to be closely monitored at divisional level.

The board recognised the importance of level 3 training and the need to monitor progress around this through the PCC going forward. The emotive and challenging nature of the work was acknowledged, as was the need to promote greater cultural change going forward.
Directors received and noted the report.

TB/2025/152 PATIENT SAFETY INCIDENT RESPONSE ASSURANCE (PSIRA) REPORT

Directors were informed that the report was missing from the pack circulated to the board the previous week and that there were no urgent matters to be escalated. It was confirmed that an external review had been commissioned to strengthen the strategic aspects of PSIRA reports and that it was intended for the first iteration of these more effective reports to be presented to the board from January 2026 onwards.
Directors noted the report.

TB/2025/153 MATERNITY AND NEONATAL SERVICES UPDATE

Miss Thompson and Mr Maher joined the meeting for this item.

The Board received an update on maternity services and noted that, following previous discussions, maternity data sets had now been incorporated into the report.

Directors were reminded that caesarean section rates had been previously identified as a corporate risk and that mapping had indicated that although the birth rate had increased over the past two years since 2024, caesarean section rates had risen disproportionately. It was reported that the projected requirement for the year was 1,300 caesarean sections (C-sections), resulting in shortfall of 480 slots. It was noted that this shortfall was being mitigated by standing down other elective activity, and that the associated risk had been formally submitted for inclusion on the Trust's risk register.

A steady decline in third- and fourth-degree tear rates observed over the past four months was also highlighted and it was confirmed that further quality improvement work was planned to address this issue. Directors noted that previous concerns regarding postpartum haemorrhage rates had been resolved, with rates returning to tolerated levels. The board was informed that neonatal data had now been incorporated as part of the perinatal data set and that robust data management processes were in place, overseen by the Family Care Divisional Management Board and Perinatal Board.

Directors went on to receive a summary overview of the Trust's progress against the 10 maternity safety actions included in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year Seven.

Safety Action 4 - Clinical Workforce: Directors were referred to the neonatal workforce data included in the report appendices and were advised that the Trust was currently reporting a deficit of 9.91 WTEs against British Association of Perinatal Medicine (BAPM) requirements. It was confirmed that this shortfall was being managed through daily risk assessments.

Safety Action 5 - Midwifery Workforce: Directors were advised that vacancy request for midwives had been approved but had not yet been formally signed off through the appropriate governance mechanisms.

Directors acknowledged significant pressure on the team due to the surge in C-section demand and noted that the situation was being managed on a daily basis. It was agreed that further investment in this area would be necessary, and that a report exploring the impact of implementing a dedicated theatre for caesarean sections was to be fully explored at the executive level and escalated to the board in due course. It was noted that this was a national issue, with changes in the landscape over the past two years requiring greater respect for

women's choices. The loss of some antenatal education provision was also identified as a contributing factor.

The board went on to reflect on the broader challenges faced by provider boards in balancing outcomes, safety, and frequent new demands, particularly in relation to staffing. The value of data sets and dashboards in the report, including Statistical Process Control (SPC) charts, was recognised but it was requested that future reports also included comparative performance data at national and local levels.

Directors were assured by the activity taking place to deliver safe, personal, and effective care in the Trust's maternity and neonatal services.

TB/2025/154 STRATEGIC RESPONSE TO NHS ENGLAND AND NW BAME ASSEMBLY ANTI-RACISM REQUIREMENTS

A report was presented outlining the Trust's strategic response to national and regional anti-racism requirements, including updates on the five main deliverable themes, an update on the Aarushi Project, and a self-assessment of areas for improvement.

Directors discussed the current political context and emphasised the importance of aligning messages and insights arising from 'safe spaces', FTSU submissions and staff networks to ensure triangulation and consistency. The Trust's commitment to inclusivity and maintaining focus on core priorities as a healthcare organisation was reaffirmed and while the board noted the positive progress made to date, it was acknowledged that more needed to be done to address the disparities that remained across concerns raised through the FTSU service, staffing, and pay gaps between different ethnic groups.

It was recognised that, while immediate operational responses were necessary, a longer-term approach would be required to address representation in senior roles through a strengthened talent pipeline. In connection with the earlier discussions around maternity services, it was noted that concerns regarding the absence of senior midwifery leaders from BAME backgrounds had been addressed, with actions undertaken to improve representation in this area. Directors agreed that trajectories had not yet been set for closing the ethnicity pay gap or other key areas and that these should be established at pace and incorporated within the Trust's forthcoming strategic refresh.

Directors approved the revised Performance Accountability Framework.

TB/2025/155 STAFF SURVEY PROGRESS UPDATE

The board received an update on the progress of the staff survey. It was reported that the current response rate stood at 37%, 2% lower than the national average but slightly ahead of the Trust's position at the same point in the previous year. It was noted that a significant event had been held on the day of the meeting to promote further uptake of the survey in addition to other measures including concluding meetings earlier to provide staff with additional time to complete their surveys. It was acknowledged that certain staff groups, including medical staff, bank staff, colleagues from BAME backgrounds, and estates and facilities remained areas of challenge in terms of survey participation.

Directors approved the Appraisal and Revalidation Report.

TB/2025/156 EAST LANCASHIRE HOSPITALS NHS TRUST ANNUAL PROVIDER SELF-ASSESSMENT 2025

Directors received, noted and approved the Trust's Annual Provider Self-Assessment for 2025.

Directors approved the Annual Provider Self-Assessment.

TB/2025/157 TRIPLE A REPORTS FROM QUALITY COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/158 TRIPLE A REPORTS FROM FINANCE AND PERFORMANCE COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/159 TRIPLE A REPORTS FROM PEOPLE AND CULTURE COMMITTEE

The reports were presented to the board for information.

Directors noted the report.

TB/2025/160 TRIPLE A REPORT FROM AUDIT AND RISK COMMITTEE

The report was presented to the board for information.

Directors noted the report.

TB/2025/161 TRIPLE A REPORT FROM TRUST CHARITABLE FUNDS COMMITTEE

The report was presented to the board for information.

Directors noted the report.

TB/2025/162 MESSAGE FROM THE BOARD

The board reflected on the importance of consistency and effective communication, noting that financial matters had remained a recurring theme throughout the discussions held in the meeting. It was agreed that the key message to staff continued to be achieving the optimal balance between finance, performance and quality was essential for future success.

It was also agreed that another key message was flu vaccination, highlighting that the most effective action individuals could take over the winter period was to receive the flu vaccination, thereby protecting themselves and others.

TB/2025/163 ANY OTHER BUSINESS

The board reiterated its gratitude to Mrs Hatch and Mr Sarwar for their valuable contribution and for bringing personal lived experience to the Trust.

TB/2025/164 DATE AND TIME OF NEXT MEETING

Wednesday, 14 January 2026 at 09:30, Trust HQ Boardroom.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Board of Directors (Open Session) Action Tracker

Key:

B	Action complete
G	Action on track for deadline
A	Action not likely to meet deadline
R	Action passed deadline

No	Meeting Date	Agenda Item	Action	Lead	Date for completion	RAG	Comments / Update
1.	September 2025	TB/2025/118: Integrated Performance Report	Dr Hobbs to liaise with NHS Resolution regarding the presentation of updated LTPS scorecard information to the Quality Committee and to the board.	Executive Medical Director	October 2025	G	the trust has met with the GIRFT litigation team and have had subsequent discussions with the Trust solicitors. A review of all cases is currently being undertaken with them for maternity, and neonates as well as for the last two years of other claims to make ensure the Trust is not an outlier and that any themes and learning are understood and implemented.
2.	September 2025	TB/2025/119: Mortality Deep Dive	An update on the ongoing implementation and development of the Trust's electronic patient record system will be presented to the board or one of its sub-committees at a future meeting.	Executive Medical Director	TBC	G	An external review of coding and mortality is underway with a view to being able to use electronic systems to improve compliance with care bundles. The trust's internal business intelligence team are developing a patient safety and patient flow dashboard to compliment this work.

3.	November 2025	TB/2025/148: Integrated Performance Report - Effective	An update on the numbers of stillbirths in the Trust will be provided at the next meeting.	Divisional Director of Midwifery and Nursing	January 2026	**B**	Complete. This will be covered under agenda item 012 – Maternity update.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/006
Report Title:	Chair's Report		
Author:	Professor Mike Thomas Chair		
Lead Director:	Professor Mike Thomas Chair		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
	✓			
Executive Summary:	The Chair's Report provides an update on the activity of the Chair since his appointment on 5th December 2025.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to note the contents of the report and approve the proposal for a Back to the Floor Programme to commence January 2026.			

Previously Considered by:	
Date:	
Outcome:	

Chair's Report

I would like to begin my first report by expressing my sincere appreciation for the warm and generous welcome I have received since joining the Trust. It has been a genuine pleasure to meet colleagues across the organisation and to see first-hand the dedication and professionalism that underpin the work of this Board. I am delighted to be taking on the role of Chair and look forward to working with you all as we continue to strengthen the Trust and care for the communities we serve.

Changes to Board

On behalf of the Board I would like to thank Graham Baldwin, whose term came to an end 5th January, for his outstanding contributions during his time with the Trust. Graham has played a significant role in strengthening the Trust's relationship with the University of Central Lancashire, which has been pivotal to our application for University Trust status. Arrangements are in place for the nomination of Graham's successor from the University, which will continue the strong relationship between our two organisations. In the meantime, I'm sure Board colleagues will join me in wishing Graham all the best for the future.

Winter Pressures

As we navigate winter pressures, I want to take this opportunity to recognise just how hard colleagues across the Trust are working. The commitment, professionalism, and compassion shown every day—often in exceptionally demanding circumstances—are deeply appreciated. On behalf of the Board, I want to extend my sincere thanks to every member of staff.

Quarter 4 2025/26

As we enter the final quarter of the financial year, there is a significant focus upon delivering our financial plan whilst also preparing our medium-term three-year plan. This will be covered more in the Chief Executive's report but I want to recognise colleagues who are working hard to ensure we meet our statutory requirements. Your efforts are essential to ensuring the Trust reaches a stable and sustainable footing for the future.

Back to the Floor Programme

One of the features of a high performing Board is to triangulate the assurance received in the Boardroom with direct observation of services and listening to the voice of staff and patients. To that end, a Back to the Floor programme will be implemented this month to complement the existing routes for Board members to be visible and gain assurance across the scope of

Trust services. Further detail is appended to this report (Appendix 1) and Corporate Governance will contact individual Board members to arrange their Back to the Floor visits. Feedback from the visits will come back to the Board via the Quality Committee.

Meetings attended during December

- Improvement & Assurance Group meetings held in December 2025 and January 2026
- Chaired Lancashire & South Cumbria Provider Collaborative Board
- Board Development Session December 2025
- Various induction meetings with key stakeholders

Appendix 1

Board of Directors

Back to the Floor Programme

'Board members need to be regularly visible to provide opportunities for staff to engage and feedback… It is essential to frequently test whether information presented in board reports matches the reality for patients and staff at service level.'

The Insightful Provider Board – NHS England

1 Purpose

1.1 The Back to the Floor programme is a key element of demonstrating the Board's commitment to hearing the voice of staff and service users. It does this by:

- Providing an opportunity for staff to share with Board Members their achievements as well as the challenges they face. The Board can then use this information to identify any areas where action would improve the working lives of staff and quality of services for patients;
- Seeking informal feedback from patients and their relatives on their experience of using the Trust's services; and
- Promoting the visibility of Board Members across the Trust and contributing to the Trust's 'Well Led' assessment.

1.2 In addition the programme provides Board Members to triangulate the information they receive with what they observe out amongst services.

1.3 It is important that these visits are carried out with an improvement mindset rather than as a compliance-based activity.

1.4 There are many visits that take place outside of the Back to the Floor programme but having a formal programme enables the Board to visit areas in a more structured, planned approach directly linked to the decisions being taken by the Board.

2 Process

2.1 All Board Members will undertake a minimum of two formal Back to the Floor visits per year.

2.2 At the start of each financial year the Director of Corporate Governance will propose a programme of visits to the Quality Committee.

2.3 In identifying the areas to be visited during the year the following will be taken into consideration:

- Areas of risk identified on the Board Assurance Framework and Corporate Risk Register;
- Services where there have been significant Waste Reduction Programme/Efficiency Savings initiatives implemented;
- Recommendations from the Quality Committee in relation to services performing well or areas where concerns have been identified; and
- Requests for a visit from services themselves.

2.4 The Corporate Governance Team has the responsibility for the practical arrangements of the Back to the Floor Programme. The team will contact the relevant services direct to agree a date for the visit.

2.5 The content of the visit will be determined by the service itself. This could comprise activities such as attending team meetings or shadowing a clinician. The service lead will provide a proposed programme for the visit in advance to the Corporate Governance Team who will share this with the Board Member visiting.

2.6 Following each visit the Board Member will complete a short template (Appendix 1) which:

- Summarises the visit;
- Identifies areas of good practice; and
- Identifies areas where improvement could be made.

2.7 The Corporate Governance Team will share the report with the service lead for factual accuracy before it is sent to the relevant Service Manager/Executive Director for information/action.

2.8 If any areas for improvement have been identified progress against actions will be tracked by the Corporate Governance Team who will report any slippage in actions to the relevant Executive Director.

3 Feedback to Services

3.1 Creating a feedback loop is essential for a transparent culture. If there have been any actions resulting from a Back to the Floor visit the Board will ensure, via the Corporate Governance Team, that feedback is provided to the service.

4 Reporting to the Board

4.1 The Director of Corporate Governance will present a bi-annual report to the Quality Committee of the visits undertaken and aspects of assurance or improvement identified.

4.2 An annual report will be presented to the Board providing an overview of the Back to the Floor visits undertaken during the previous year and reviewing the effectiveness of the programme.

Approved by: The Board of Directors

Date of Approval:

Date of Review:

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Appendix 1

Back to the Floor Template

Please return the completed form within two weeks of your Back to the Floor visit to the Corporate Governance Team corporate.governance@elht.nhs.uk

Date of Back to the Floor:	
Board Member visiting:	
Service visited:	
Service Lead:	

Section 1: Please include a short summary of your visit.
Section 2: Identify any areas of good practice.
Section 3: Identify any areas of improvement, which require action.
Date of Report:

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/007
Report Title:	Chief Executive's Report		
Author:	Shelley Wright, Executive Director of Communications		
Lead Director:	Martin Hodgson, Chief Executive		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	This report provides national, regional and Trust-specific updates across the NHS and wider health and social care system which are material to the delivery of organisational aims and the provision of safe, personal and effective care to patients. It includes information about ongoing initiatives, high level performance data, updates on the use of the Trust Seal and seeks to celebrate good practice and success in teams and for individual colleagues.			
Key Issues/Areas of Concern:	None			
Action Required by the Committee:	None			

Previously Considered by:	None
Date:	
Outcome:	

1. Background

This report is divided into sections covering the following:

- National headlines relevant to the NHS and wider health and social care economy
- News and information from across the North West and Lancashire and South Cumbria system area, including details from the Integrated Care Board (ICB) and Provider Collaborative Board (PCB)
- Local and Trust specific updates

2. National Updates

Top NHS trusts given new powers to improve care

From April 2026, Advanced Foundation Trusts (AFTs) will be introduced to give NHS trusts more freedom in how they operate and plan services.

The new model aims to improve quality, strengthen collaboration, and speed up progress on national priorities—especially the move towards community based and preventative care.

Trusts will have more flexibility to design services and use resources in ways that best suit their local communities.

An initial group of high performing trusts has been chosen for assessment based on strong care quality, good finances, and effective partnerships. More groups will follow, with the goal of all NHS providers becoming AFTs by 2035, helping to raise standards across the system.

Neighbourhood Health Centres bring patient care closer to home

250 new health ‘one stop shops’ will bring the right local combination from GPs, nurses, dentists and pharmacists together under one roof to best meet the needs of the community, starting in the most deprived areas.

The centres will be part of a new Neighbourhood Health Service that will provide end-to-end care and tailored support - improving access to GPs, helping to prevent complications and avoid the frustration of being passed around the system.

As the Neighbourhood Health Service moves more outpatient care out of hospitals, these centres will provide space for clinics in communities across the country – bringing an end to the postcode lottery of access to healthcare.

Patients will get treatment minutes from home instead of travelling miles to often hard to reach hospitals, so the NHS is organised around patients’ needs - rather than patients organising their lives around the NHS.

Neighbourhood health services will initially focus on improving access to general practice and supporting people with complex needs and long-term conditions - like

diabetes and heart failure - in the areas of the highest deprivation. As the programme grows, it will expand to support other patients and priority cohorts.

Early flu wave could lead to 'long and drawn out' winter

The flu season hit the NHS more than a month earlier than usual, with cases three times higher than the same time last year.

The early increase prompted concerns of flu spreading into the wider population and triggering a "long and drawn-out flu season".

An average of 2,660 patients per day were in a hospital bed with flu at the start of December – the highest ever for the equivalent time of year and up 55% up on the week before.

NHS teams increased efforts through its autumn/winter flu vaccination campaign to prevent further spreading of the virus.

Industrial action by resident doctors

Resident doctors across the country took part in industrial action twice since the last Board meeting.

The British Medical Association is in dispute with the Government over pay and jobs. Strikes took place between 14-19 November and 17-22 December.

Plans were put in place by the Trust and an incident co-ordination centre managed the situation to support any emerging issues.

Nationally, the NHS met its goal to maintain 95% of planned care during the early December round of strike action – surpassing the 93% protected during earlier industrial action in July – while still maintaining critical services, including maternity services and urgent cancer care.

NHS maternity signal system will spot emerging safety concerns

A safety signal system is being rolled out across NHS maternity services in England.

The sophisticated new tool rapidly analyses data being routinely recorded by maternity teams on wards to spot whether there are potential emerging safety issues which need urgent attention and action.

If the system detects a pattern or trend in the data which seems out of the ordinary, it will send out a warning signal indicating a safety check should be urgently carried out on that unit.

Once a signal is generated, it is mandatory for the maternity unit to carry out a critical safety check within eight working days and share action taken with regional and national teams.

Forecasting tool to tackle A&E bottlenecks

An artificial intelligence tool has been launched to help predict when A&E departments will be busiest.

Available to all NHS Trusts, it is already in use by 50 NHS organisations - helping them plan how many people are likely to need emergency care and treatment on any given day.

This means smarter planning for shifts and bed space in the long-term, reducing last-minute pressure thanks to clearer forecasts which spot potential bottlenecks.

With the tool being constantly trained on seasonal health data, it will help to spot surges in demand for health services before they happen - giving hospitals the opportunity to put staff in the right place at the right time.

The tool uses this data to highlight regular pinch points where demand is likely to be higher across the course of the year. That includes a wide range of areas, from Met Office temperature forecasts and hospital admissions through to which days of the week are busier than others.

This data then produces forecasts for the coming days and weeks which hospitals can use to more effectively manage resources.

NHS AI trial to diagnose prostate cancer

The NHS will test an AI-powered ‘one-day diagnostics’ service for prostate cancer that could transform diagnosis and save some men up to a month of waiting.

The new ‘one stop shop’ pilot will use artificial intelligence to interpret MRI scans for men with suspected prostate cancer, helping spot lesions in a matter of minutes.

This should give doctors everything they need to either potentially give an all clear the same day or confirm a cancer diagnosis a few days later following review.

Almost every GP now offers online access for patients

GP online access has been rolled out at 98.7% GP practices in England, meaning patients at nearly all GP practices can now submit online consultation requests during work hours (8am to 6.30pm).

A record 8 million online requests were submitted by patients in October - an increase of one-fifth on the previous month and an increase of two-thirds on last year.

For the first time the Office for National Statistics Health Insight Survey shows that, of those who completed this survey, more contacted their GP practice online than by phone.

Digital revolution in care saves millions of admin hours

Four in five care providers now use digital social care records (DSCR), helping almost 90% of people who draw on care.

DSCRs are an essential part of the government's ambition to develop a single patient record as part of the 10 Year Health Plan.

They also allow care plans - which set out people's care needs and required medications - to be completed and signed off in three days instead of seven and for them to be reviewed in half an hour instead of four hours.

Government unveils England's first ever men's health strategy

Men and boys across England will benefit from tailored healthcare and support as the government launches its first men's health strategy.

Launched on International Men's Day, the plan sets out comprehensive action to tackle the physical and mental health challenges men and boys face every day.

Men can be less likely to seek help and more likely to suffer in silence. This, combined with a higher propensity to smoke, drink, gamble and use drugs, means men's health is suffering, having a significant impact on families, workplaces and communities. This strategy will help give men and boys to get on and live longer, healthier lives.

Voluntary redundancy scheme

Following the announcement last year about the abolition of NHS England, a national model voluntary redundancy scheme has now been agreed with the Government.

This is to progress the reconfiguration of NHS England and the shift of purpose for ICBs to be Strategic Commissioning organisations.

Last year the Government announced NHS England would be brought back into DHSC to end duplication.

3. Regional Updates

Quality of care and patient experience in emergency departments

As part of ongoing work to plan for expected winter pressures, the ICB carried out quality visits to urgent and emergency care services across Lancashire and South Cumbria.

It put forward a series of recommendations to trusts, including around improving communication with patients about waiting times and enhancing privacy and dignity in waiting areas.

These steps aim to ensure vulnerable patients receive the care and support they need, with robust follow-up and continuity of care.

At ELHT, the quality visits reviewed ED pathways for patients with mental health conditions and learning disabilities, as well as corridor care.

Further quality visits are planned to assess progress.

Cervical screening buses offering drop-in appointments at Lancashire locations

A mobile cervical screening service will be available in locations across Lancashire in the new year, in a bid to reach areas with low uptake.

Living Well buses will visit venues in the region throughout January, offering free drop-in cervical screening appointments to women and people with a cervix aged from 25 to 64 who have missed their previous bookings, are overdue a screening, or have never been screened.

Just like a visit to a GP, the bus will provide a safe, comfortable and private area for cervical screening appointments to take place.

Critical Care Network implements new prescribing guideline for antibiotics

Lancashire and South Cumbria Critical Care Network has developed a new prescribing guideline for how antibiotics are prescribed and administered for critical care patients across the region.

The change aims to save lives of patients with severe infections, such as sepsis.

It follows the publication of a randomised clinical trial in 2024 (BLING III) and subsequent position statement from the British Infection Association and Intensive Care Society.

Extra urgent dental appointments now available for people in Lancashire and South Cumbria

Additional urgent dental appointments are being offered in local NHS dental practices in Lancashire and South Cumbria.

They are open to people in need of urgent or unscheduled care and not for routine dental care.

It’s part of a national initiative that is seeing a total of 700,000 extra urgent dental appointments being rolled out across the country.

ICB renews agreement with VCFSE sector

Lancashire and South Cumbria Integrated Care Board (ICB) has strengthened its commitment to working with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector by renewing their partnership agreement.

ICB chair Emma Woollett and VCFSE Alliance chair Tracy Hopkins signed the agreement at November's ICB board meeting.

The agreement continues the arrangement for the ICB to invest in VCFSE services and cements the long-term goal of creating a more equitable relationship between health and the voluntary sector, as well as strengthening its connection with communities in Lancashire and South Cumbria.

Area SEND inspection for Blackburn with Darwen

Ofsted and the Care Quality Commission (CQC) carried out an inspection of education, health and care services for children and young people with special educational needs and disabilities (SEND) in Blackburn with Darwen. This type of inspection is called an area SEND inspection.

A key part of the area SEND inspection is to gather the views of children and young people themselves, plus their parents and carers, as well as the professionals who support them.

The inspection lasted for three weeks, from 24 November to 12 December.

4. Local and Trust specific updates

Use of the Trust Seal

The Trust seal has been applied to the following documents since the last report to the Board:

- The lease for Suite 12 of the Globe Centre, Accrington between the Trust and Community Health Partnerships Ltd.

- A supplementary agreement for additional works (variation 497) between the Trust and Consort Healthcare Blackburn.

- A contract for Integrated School Nurses (0-19 service) between the Trust and Blackburn with Darwen Borough Council.

- The underlease for part of the Acorn Primary Health Care Centre, Accrington, between the Trust and Community Health Partnerships Ltd.

Finance headlines

The Trust is continuing to work through its financial recovery plan, and teams across all areas are focusing on bringing costs down by March 2026.

More than £20m of efficiencies have already been delivered – the highest amount achieved in a single year - and spend on pay has reduced by around £6m. This has been done whilst also improving our productivity and the quality of our care.

Detailed updates are shared with the Board separately but some of the key pieces of work are highlighted below.

- A temporary freeze has been put in place on non-pay spend. This is affecting items not directly linked to patient care, including stationery, computer hardware, crockery, clothing and training materials.

- A daily variable pay control panel has been expanded to now also review requests for all medical and dental agency staff. This is adding an additional layer of scrutiny to all temporary requests for staffing.

- There has been a review of the expenses claims process to ensure consistent application of the existing guidance.

- A review of stock management has taken place, looking at whether the volume of stock is needed, whether there are alternative stock options, stock that isn't used anymore that could be recycled and generating ideas from teams about how things might be done differently.

- Following suggestions from colleagues, an audit was carried out which highlighted widespread overuse of disposable green plastic aprons beyond their intended purpose, particularly outside of mealtimes. Through targeted communication and reinforcement of policy, apron use is now limited to meal service and feeding assistance, reducing both waste and environmental impact.

- A 'gloves off' campaign is challenging the unnecessary use of disposable gloves, reinforcing proper hand hygiene practices instead. Supported by national learning from Great Ormond Street Hospital, the scheme aims to reduce glove ordering and related costs.

Winter pressures

Demand on services across the Trust has increased, with an average of 60 more patients a day attending the Emergency Department at Royal Blackburn Teaching Hospital (RBTH) compared to the previous year.

Teams are working hard to care for and treat all patients but with such a rise in numbers, it has meant there have been some crowded waiting rooms, long waits for admission to hospital and some patients receiving corridor care.

Work is constantly taking place to review what else could be done to reduce site pressures to support patients and improve their experience.

Improvements made in recent months includes strengthening senior nurse support, additional support in the A&E department for patients who are stabilised and awaiting admission and a live dashboard for nursing teams to increase visibility of assessments.

A new Medical Decisions Unit (MDU) has also opened and available 24 hours a day. Led by the Acute Medical Team, its main focus is admission avoidance, whilst improving care for patients, cutting delays, reducing corridor care and enhancing safety.

Visit by NHS North West

NHS North West Regional Director, Louise Shepherd, Louise Shepherd, visited RBTH to find out more about the work taking place at the Trust.

She visited several departments and met with teams, gaining first hand insight into the daily challenges being navigated.

Colleagues shared their experiences openly, highlighting the realities of frontline care, the impact of rising demand and the innovative ways teams continue to support patients and each other.

Medium term planning

Last month the Trust put forward its first submission as part of the NHS Medium Term Planning Framework (MTPF), which sets out plans for the next three years.

The MTPF was published nationally in October and includes a range of targets, including improving elective care reducing waiting times and improving patient experience, along with financial and workforce expectations. The framework focusses on medium-to-long term planning to help drive the strategic shifts set out in the 10 Year Health Plan.

All NHS providers were required to submit their first draft before Christmas and plans are expected to be finalised in February. It includes an overview of how we will meet the needs of our local population, how we will implement the 10 Year Health Plan and evidence of partnership working.

In East Lancashire the foundations of this activity are already in place and the approved plan will coincide with the launch of a newly refreshed five year strategy, so although it is ambitious the Trust is in a great starting point to deliver it.

Virtual wards milestone sees 45,000 patients cared for at home

A community-based service launched by the Trust three years ago is seeing more patients than ever.

Now in its third year, the Trust's virtual wards programme, Hospital at Home, has seen more than 45,000 patients being treated in the comfort of their own home instead of being admitted to hospital.

Through a virtual ward approach, patients are assessed, treated and supported at home, helping to reduce the pressure on the Trust's inpatient wards and services and freeing up space for others to receive care quicker.

Hospital at Home service took centre stage at a national conference, as Consultant Practitioner Natasha Dalton and Advanced Clinical Practitioner Amy Ross were invited to deliver the keynote presentation at the NHS Virtual Wards Summit.

The Trust has the highest capacity and utilisation rate of virtual wards through Hospital at Home among providers across Lancashire and South Cumbria.

Trust introduces new learning disability and autism training

The Oliver McGowan training about learning disability and autism has now been formally introduced as a requirement for all staff across the organisation. The rollout follows national guidance aimed at improving understanding and awareness of the needs of people with a learning disability or autism in health and care settings.

The training was developed in response to the death of Oliver McGowan, whose case highlighted significant gaps in knowledge and the need for better, more consistent education. The programme provides essential insight into how to deliver safer, more personalised and respectful care.

The introduction of this mandatory programme marks a key step in strengthening the quality and inclusivity of care provided across the Trust.

Staff survey

The Trust's National NHS Staff Survey campaign ran from 15 September to 28 November.

The final response rate for the Trust was 42.9%, which represents a 1% increase on the previous year.

The survey is an important way for staff voices to be heard and the results will help shape improvements across the organisation. Findings are expected to be shared in spring, along with the key themes and next steps.

Thousands of staff are vaccinated

Nearly 4,000 colleagues have now received their flu vaccination. This year there were more ways to take up the free vaccination offer than ever before.

In addition to appointments with Occupational Health, drop-in sessions around the Trust and roving vaccinators who were calling into workplaces, a vaccination bus visited sites across East Lancashire.

Although the roving vaccinators are no longer available, staff still have the opportunity to have the flu vaccine until the end of March by making an appointment with Occupational Health or their local GP.

Record £2m donation set to transform patient care

A landmark £2m donation has been made to ELHT&Me by The Kay Family Foundation — the largest single gift in the charity's history. The foundation, which supports initiatives that improve health, wellbeing and community life in East Lancashire, has directed the funding towards a range of projects.

The donation will fund a wide range of equipment and technology, including:

- Visual field machines to speed up diagnosis of eye conditions
- 13 advanced neonatal incubators to support newborns in NICU
- Mobile X ray machines enabling faster bedside imaging
- An additional scalp cooler for patients undergoing chemotherapy
- 18 community bladder scanners to reduce unnecessary catheterisation and avoid hospital visits

The investment is expected to deliver long lasting improvements in patient experience and clinical outcomes across East Lancashire.

Significant investment awarded to boost safety and infrastructure

The Trust has received a £1million grant to upgrade electricity supplies and wiring, improve ventilation systems and replace key water mains at Burnley General Teaching Hospital.

Work began in December 2025 and will run through to March 2026.

The funding, successfully bid for from the national NHS Estates Safety Fund will deliver 20 essential electrical and mechanical projects which will significantly enhance safety, reliability and resilience across Trust facilities.

The Estates Safety Fund was introduced following the Autumn Budget 2024, where the Chancellor confirmed £750 million in capital funding for 2025–26 to tackle critical infrastructure and safety risks in NHS hospital buildings.

These improvements will help reduce backlog maintenance, improve compliance with safety standards and ensure continuity of patient care by preventing avoidable disruptions.

Single pathology service

Engagement roadshows have been taking place as part of preparations for the planned launch of the Lancashire and South Cumbria Pathology Single Service.

The single service is due to go live on 1 February and is a collaborative programme bringing together the pathology services of the four NHS trusts, including ELHT.

The trusts currently run their own pathology laboratories, each with different systems, equipment and processes. The single service aims to bring these services together into one coordinated, standardised network.

Launch of pharmacy research group

A new pharmacy research group has been launched to boost research activity across the pharmacy workforce and embed research as a routine part of clinical practice.

Meeting quarterly, the group is focused on developing research skills, raising the profile of pharmacy-led studies and sharing the impact of ongoing work across the Trust.

Early achievements are already making an impression. Several pharmacists have completed Associate Principal Investigator (API) Scheme applications, members have secured competitive personal research awards from major funders including NIHR and Pharmacy Research UK, and the Trust has seen its first pharmacist act as Principal Investigator for a dermatology study.

The group now plans to widen its membership to include more pharmacists and pharmacy technicians, opening the door to greater involvement in research and helping to integrate evidence-based practice into everyday pharmacy care.

Rovers Reach project: Making research accessible in East Lancashire

The Trust has teamed up with Blackburn Rovers Community Trust and the NIHR Regional Research Delivery Network Northwest Coast to launch Rovers Reach – a new initiative designed to boost awareness of health and social care research and make it easier for local people to get involved.

A key part of the project is promoting Be Part of Research, the national service that helps members of the public find and join research studies across the UK.

To help spread the word, sign up details are now featured on the rotating digital screen outside Ewood Park, putting research opportunities in front of thousands of fans and visitors every week.

The partnership aims to open doors for more people to take part in studies that shape the future of care, while strengthening links between the Trust and the communities it serves.

Surgical hub recognised for meeting top clinical and operational standards

The Burnley Elective Surgical Hub at BGTH has been accredited by NHS England's Getting It Right First Time (GIRFT) programme for delivering high standards in clinical and operational practice.

The scheme, run in collaboration with the Royal College of Surgeons of England (RCS) and supported by the Royal College of Anaesthetists, assesses surgical hubs against a framework of standards.

The GIRFT team visited the hub to evaluate against five main elements: the patient pathway, workforce and training, clinical governance and outcomes, facilities and ring-fencing and utilisation and productivity.

Award for collaborative work in Accrington

A collaborative project to transfer services from Accrington Victoria Hospital to the Acorn Primary Health Care Centre has won the Public/Private Sector Collaboration Award for Healthcare at the Operational PPP Awards.

The move followed the difficult decision to close Accrington Victoria, which was no longer fit for healthcare provision.

Achieving this move required extensive reconfiguration of the Accrington Acorn facility, alongside the navigation of complex legal and financial arrangements, securing Department of Health and Social Care funding, and coordinating multiple partners across the public and private sectors.

Thanks to this significant behind the scenes work, local residents continue to benefit from primary care, outpatients, minor injuries, and X ray services close to home, while improving GP services in the area.

Get into ELHT celebration

A celebration event was held in December for the latest group of people who have completed the King's Trust programme, which includes work experience at ELHT.

The Get into ELHT programme is a three-week long placement run in conjunction with the charity that sees young people gain valuable work experience across a variety of hospital departments.

The 11 young people joined the initiative to improve their skills and experience, which in turn helps them to achieve long-term employment.

More than 200 have been welcomed to ELHT through the programme since 2017, with many being offered a role at the Trust.

East Lancashire community nurses awarded prestigious Queen's Nurse title

Four community nurses at East Lancashire Hospitals NHS Trust have been given the prestigious title of Queen's Nurse.

Amanda Prescott, Amy Rogers, Rebecca Smith and Debbie Hood, who all work in the Trust's Family & Community Care Group, were handed the accolade by nursing charity The Queen's Nursing Institute (QNI) for their commitment to high standards of patient care, learning and leadership.

It follows a rigorous application process which required detailed evidence of professional practice and feedback from colleagues, patients and families.

Christmas cheer at the Trust

In the run up to Christmas, teams across the Trust worked hard to keep spirits high during what was an exceptionally busy period. Despite significant operational pressures, a programme of festive activities helped bring moments of joy to patients, visitors and staff.

Local football clubs played a big part in spreading cheer, with players from Burnley FC and Blackburn Rovers making special visits to wards and a series of ticket giveaways to Rovers offered staff the chance to enjoy a matchday break.

Choirs and community bands performed seasonal favourites at RBTH, while Christmas themed pop ups in the restaurants added to the atmosphere.

The chapel also hosted a number of religious services, providing space for reflection and celebration for those who wished to take part.

A digital advent calendar delivered daily surprises throughout December, adding a light-hearted lift to inboxes each morning.

One of the most heart warming contributions came from the community, with thousands of gifts donated for both patients and colleagues. Local people, schools, businesses and organisations once again demonstrated extraordinary generosity, ensuring that no one spending Christmas in hospital was forgotten.

Together, these efforts brought a welcome sense of togetherness at a time when it was needed most, showing the strength and kindness of the communities the Trust serves.

ENDS

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BOARD OF DIRECTORS

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/008
Report Title:	Provider Collaborative Board Update		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Martin Hodgson Chief Executive		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Approval**	**For Information**
	✓			
Executive Summary:	This report provides an overview from the discussions at Provider Collaborative Board meetings held in November. The December meeting was stood down with the next meeting to take place on 15th January 2026.			
Key Issues/Areas of Concern:				
Action Required by the Board:	The Board asked to note the contents of the report.			

Previously Considered by:	
Date:	
Outcome:	

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Provider Collaboration Board (PCB) Update

Summary of discussion 13 November 2025

1 Changes to PCB Membership

Arron Cummins was welcomed to the PCB Board in his new capacity as Chief Executive of the Lancashire and South Cumbria (LSC) Integrated Care Board (ICB). PCB members thanked Shazad Sarwar for his contribution whilst Chair of ELHT and noted Mike Thomas has been confirmed as Interim Chair of ELHT for a term of 18 months.

2 Urogynaecology Service Transformation Update

The Urogynaecology service supports women with pelvic floor disorders and urinary incontinence, conditions affecting up to one in three women. Across the four acute Trusts in Lancashire and South Cumbria, around 4,500 referrals are received each year.

Modelling shows that about 70% of referrals do not need a consultant-led first appointment, and up to 60% can be managed through physiotherapy-led triage, with the remainder handled in primary or community care. This redesigned pathway could remove roughly 3,000 hospital appointments annually and save around £450k in consultant outpatient costs.

Early results following the introduction of physiotherapy-led triage and a Urogynaecology locum show significant improvement, with forecast backlogs reducing to 99 patients in October and 41 in November 2025.

The work aligns with the Provider Collaborative Board's aims to improve financial sustainability, population health, workforce wellbeing, and provide high quality services. The Board noted that the collaborative approach will create more efficient pathways, faster patient support, and lower costs, with stronger neighbourhood-based care.

A further update is planned for ExCo in December 2025, including a recommended standardised pathway, a plan to treat all 65-week patients, and a timetable for remaining actions.

3 Finance and Planning Update

The NHS released its Medium-term Planning Framework for 2026/27–2028/29 on 24 October 2025, outlining expectations across performance, finance, quality, and workforce. Systems must submit an initial plan to NHSE before Christmas, with a final version due in February 2026.

The ICB has shared early commissioning intentions and contractual plans for 2026/27, supported by a workshop held on 29 October. Work is underway to assess the impact of wider commissioning intentions, with completion expected by the end of November. A major task remains in agreeing three-year priorities that align with national and local goals.

The System Planning Group meets weekly to coordinate planning, now with PSC involvement to support the quantification of commissioning intentions. Trusts are developing their first submissions while also forecasting 2025/26 operational and financial positions to establish a baseline.

A key risk is the lack of detailed technical and financial guidance, including allocations. Significant changes are anticipated, but without confirmed financial parameters, it is difficult to determine what levels of activity and performance will be affordable.

4 Financial Risk Share Principles

A financial risk-share framework has been created and reviewed by finance leaders from NHS providers and the Lancashire and South Cumbria ICB to support the development of new service models and cross-organisational change. The framework sets out ten principles designed to manage risk, clarify responsibilities, and reduce the impact of financial pressures, with the flexibility to be adapted or expanded as needed over time.

5 EPR Next Steps: Memorandum of Understanding (MoU) for Digital, Data and Technology (DDaT)

By 2030, the first of the One LSC provider Trusts will need to procure a new Electronic Patient Record (EPR) system. All of the provider organisations are working collaboratively on the outline business case.

A refreshed Memorandum of Understanding (MoU) has been developed between the Lancashire and South Cumbria ICB and the region's NHS Trusts, replacing the 2021 version and building on previous collaboration agreements to support the digital strategy for 2024–2029.

Although LSCFT will retain its current mental-health-specific EPR, it will continue to participate in the wider procurement process. Each Trust must now take the MoU through its own governance processes.

6 ICB Updates

The new ICB CEO has launched a management-of-change process, including a revised Executive structure with posts to be advertised in early December 2025. A voluntary redundancy scheme has been initiated, with consultations lasting 30–40 days and outcomes confirmed in January 2026, aiming for departures by the end of March. Over half of the LSC ICB workforce is at risk, creating a substantial workload that may delay ongoing projects. Once the new team is in place, they will meet with PCB members after settling into their roles.

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TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/009
Report Title:	Financial Performance Report Month 8 2025/26		
Author:	Mr M Greatrex, Interim Deputy Director of Finance		
Lead Director:	Mrs S Simpson, Executive Director of Finance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
		X		

Executive Summary:

At month 8, the Trust is reporting an in-month deficit of £5.92m, against a planned deficit of £2.76m; £3.16m behind the plan.

The year-to-date (YTD) position is a £46.9m deficit against a planned deficit of £33.5m; £13.4m behind plan (includes the original WRP plan and excludes the DSF).

The WRP delivered £3.5m in month which is £3m behind the revised plan (£2.5m adverse to the original PFR plan) although £0.6m previously reported as a mitigation was reclassified as WRP in month therefore reporting £4.1m WRP in M08.

The WRP has delivered £25.5m YTD which is £9m behind the revised plan; however, this is £10.8m adverse to the original PFR YTD plan.

Key Metrics
Agency spend of £308k, is £201k better than the in-month plan and represents a 64% reduction on the 2024/25 run rate.

Bank spend of £4.348m is £802k adverse to the in-month plan with the increase against M07 relating primarily to industrial action. The in-month expenditure represents a 4% reduction on 2024/25 run rate.

The cash balance at the end of November was £15m, a decrease of £0.9m compared to M7.

The annual 2025/26 capital plan is £42m at M8, YTD spend is £15.4m, £3.4m ahead of plan. Expenditure to date includes £13.4m internally funded and £2m externally funded with PDC.

Paid WTE have increased by 81 WTE from Month 7 to 9,682. Within this movement 27 relate to an error in the M7 reporting that led to an overstatement of last month's reduction linked to a 5-week month. This has been corrected in M8. The underlying increase of 54 WTE included 22 relating to MECs NQN that are substantive. Bank WTE went up by 16 linked to Industrial Action.

Key Issues/Areas of Concern:	The Trust's financial plan for 2025/26 is break-even, including £43.3m deficit support funding (DSF) that is subject to delivery of the plan. The key risks associated with delivery of the plan include: • Full delivery of the Waste Reduction Programme of £60.8m on a recurrent basis. • Cash flow forecasting indicates a significant challenge by M10 2025 although the Trust is awaiting the outcome of a Revenue Support PDC application to offset the DSF unpaid in M08, and at risk for the remainder of the financial year. • For the Capital Programme, PDC must be spent in the year of draw down and will impact upon the Trust's cash balance which as mentioned above is negatively affected by the withholding of DSF, under-delivery of WRP and in year operational pressures. This may cause a risk to the internally funded programme that may need to be curtailed. • Divisional pressures to be contained within the agreed budgets/ plan although these have shown signs of stabilising since M06 • The finalised impact of the HCA review of banding inclusive of the associated timescales for both cash and revenue. • The financial impact of any further industrial action, following the further action in M09. • The impact of Deficit Support Funding being withheld past M08 as mentioned above (cash and delivery of plan).
Action Required by the Committee:	Note the content of the report.

Previously Considered by:	Finance and Performance Committee
Date:	22 December 2025
Outcome:	Noted

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M08 Financial Performance Trust Board

14th January 2026

Month 8 Key Headlines

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Summary of Financial Position

- In month **deficit of £5.92m**, against **deficit plan of £2.76m** therefore **£3.16m behind the plan**.
- DSF not received in month therefore £3.6m negative impact on income is included in the reported position
- YTD **deficit of £46.9m** against deficit plan of £33.5m therefore **£13.4m behind plan** (excluding planned DSF).
- In month **WRP delivered £3.5m** against the WRP Delivery plan, therefore **£3m adverse to plan** (£2.5m adverse to PFR plan) (£4.1m reported in month to correct the YTD WRP value)
- YTD **WRP delivered £25.5m** against the WRP Delivery plan, therefore **£9m behind plan**. (£10.8m adverse to PFR YTD plan)
- **Cash balance** at the end of November was **£15m**, a reduction of £0.9m compared to M7 cash position of £15.9m.
- **Capital** plan 2025/26 is £42.0m. At M8, spend is **£15.4m**, £3.4m ahead of plan.
- Paid/worked WTE have increased by 81 WTE from Month 7 to **9,682** (includes a correction to M07)

M8 FPR Plan vs Actual

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Monthly Actuals	Current Plan	Current Actual	Variance to
	£000	£000	£000
Operating Income: Patient Care	63,870	60,851	(3,019)
Other Operating Income	3,890	4,489	599
Total Income	**67,760**	**65,340**	**(2,420)**
Substantive	(41,142)	(42,958)	(1,815)
Variable Pay: Overtime	(43)	(39)	3
Variable Pay: WLI / Extras	(355)	(498)	(143)
Variable Pay: Bank	(3,546)	(4,348)	(802)
Variable Pay: Agency	(509)	(308)	201
Other Staff Costs	(192)	(173)	19
Total Pay	**(45,787)**	**(48,325)**	**(2,538)**
Supplies & Services Clinical	(3,695)	(5,045)	(1,350)
Drugs	(4,486)	(4,982)	(496)
Other Non Pay	(11,322)	(11,542)	(220)
Total Non Pay	**(19,503)**	**(21,569)**	**(2,066)**
Total Expenditure	**(65,290)**	**(69,894)**	**(4,604)**
Net Expenditure	**2,470**	**(4,554)**	**(7,024)**
Non Operating Movements	(436)	(358)	78
Operating Surplus (Deficit)	**2,034**	**(4,912)**	**(6,946)**
Other Non Operating Movements	(1,179)	(1,012)	167
Adjusted Financial Performance Surplus (Deficit)	**855**	**(5,924)**	**(6,779)**
Deficit support Funding	(3,610)	0	(3,610)
Adjusted Financial Performance Surplus (Deficit)	**(2,755)**	**(5,924)**	**(3,168)**

	£m	R	NR
Income Plan	67.8		
DSF	-3.6		x
Offset (HCD/Clear)	0.9	x	
Depreciation Income Reduction	-0.5		x
ERF	0.3		x
WRP Delivered: Carpark	0.4		x
HEE Benefit	0.2		x
Income Actual	65.3		

	£m	R	NR
Pay Plan	45.8		
Industrial Action	0.46		x
Bank Holiday Benefit	-0.15	x	
Pension pressure	0.12	x	
Recovery Support	0.09	x	
Other Pay Pressures	0.11	x	x
Underdelivery WRP	1.90	x	
Pay Actual	48.33		

	£m	R	NR
Non-Pay Plan	19.5		
Offset by Income	0.9	x	
Recovery Support	0.2	x	
Increase in consumables	0.1		x
Backdated benefits	-0.1	x	x
Under delivery WRP	1.0	x	
Non-Pay Actual	21.57		

Drivers of Variance in M08

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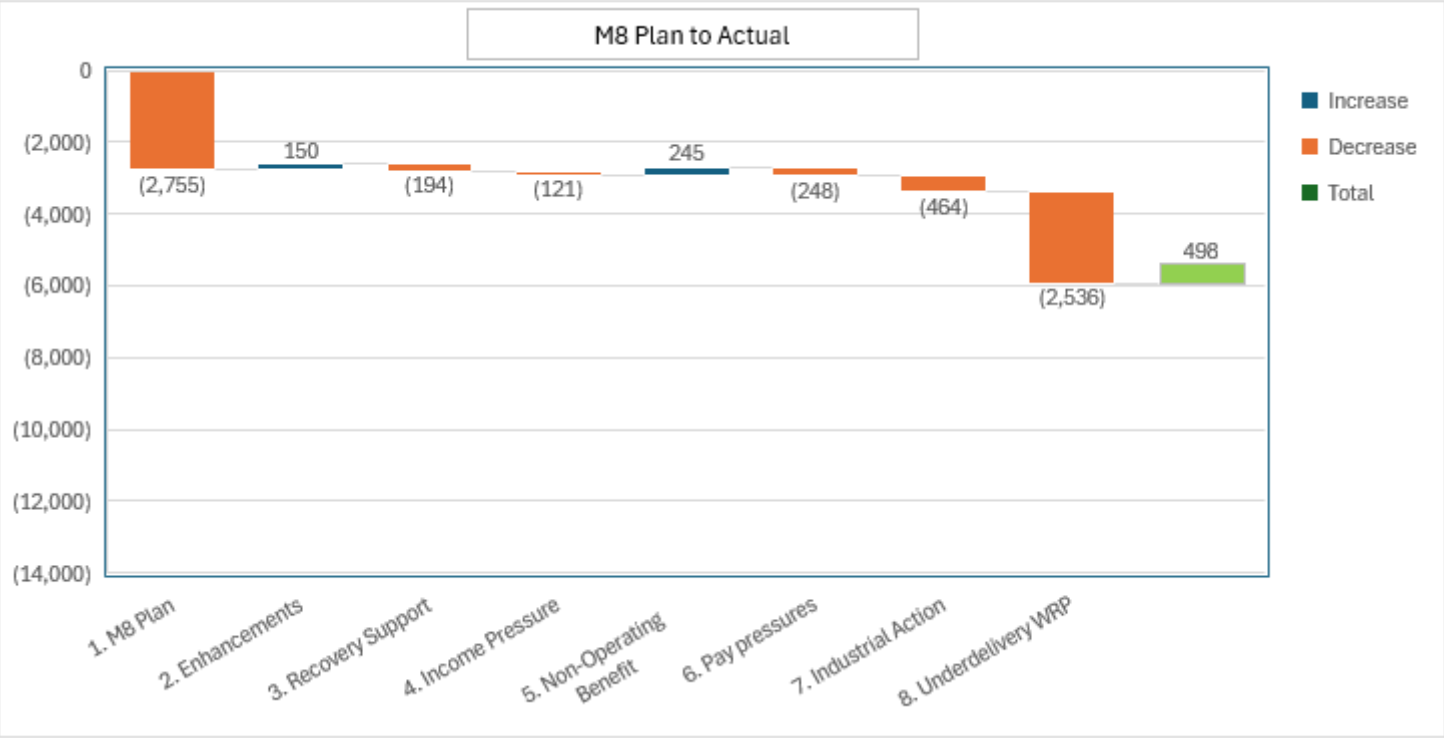

1. **M8 Plan** £2.76m Deficit
2. **Bank Holiday Enhancements** £0.15m
3. **Recovery Support** £0.2m (£0.26m, offset with some RSP income)
4. **Income Pressure :** £0.1m: Depreciation income pressure (£0.5m) offset by ERF in-month (£0.3m)
5. **Non-operating benefit:** £0.2m favourable linked to a benefit on the PFI
6. **Pay Pressures** £0.2m: majority pension opt-in
7. **Industrial Action** £0.5m
8. **Undelivered WRP** £2.5m pay and non-pay
9. **M8 Actual** £5.92m Deficit

***Impact of reprofiled WRP £0.5m**

Drivers of variance YTD

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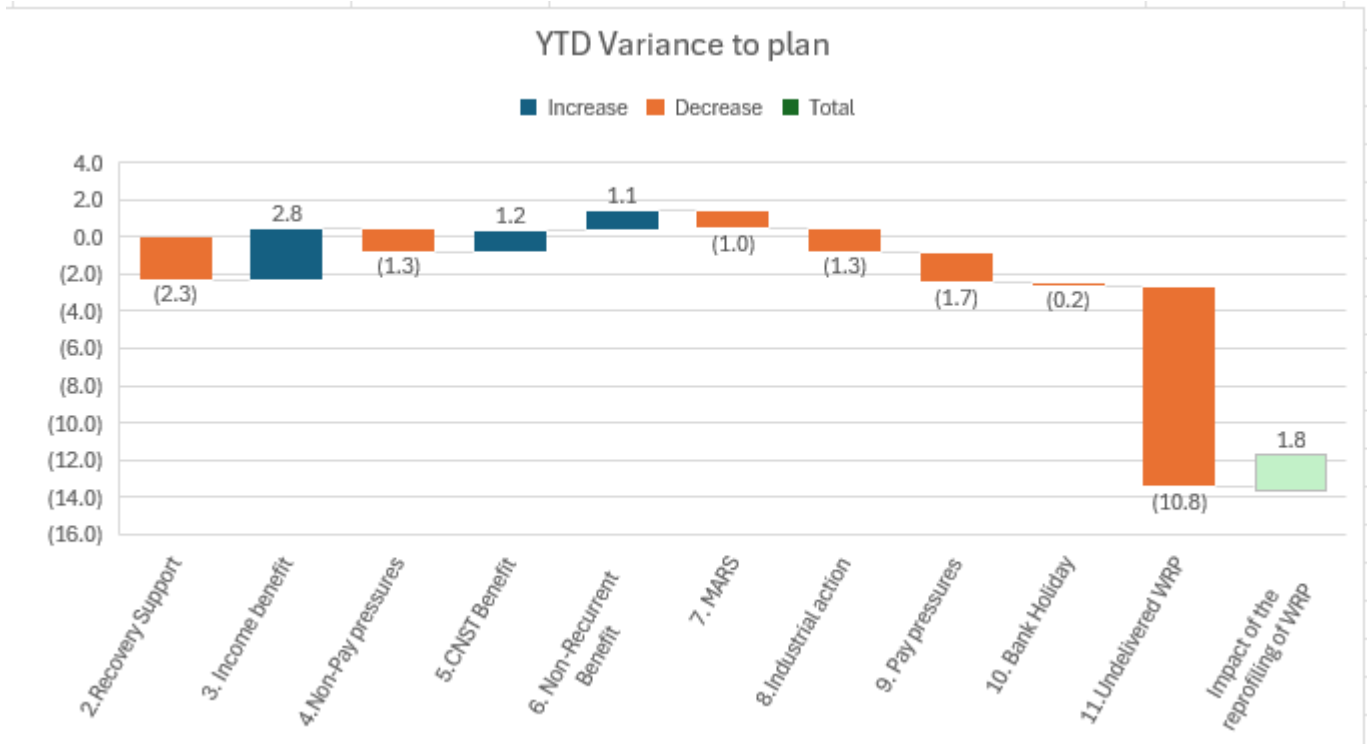

1. **YTD Plan** £33.5m Deficit
2. **Recovery Support** pressure £2.3m
3. **Income benefit** £2.8m (ERF, CPD and bowel screening, Depreciation income, Carparking)
4. **Non-pay** pressures £1.3m (PFI, Stocks, Utilities)
5. **CNST** one-off benefit £1.2m
6. **Non- Recurrent HCA** benefit £1.1m
7. **MARS** pressure £1m
8. **Industrial Action** pressure £1.3m
9. **NR Pay** Pressures £1.7m, backdated pay and pension opt-in
10. **Bank Holiday Benefit** £0.2m
11. **Undelivered WRP** pressure £10.8m
12. **YTD Actual** £46.9m Deficit

WRP – Performance to reprofiled plan

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Month 8	WRP		
	Plan	Actual	Variance
	£000	£000	£000
Income	154	547	393
Pay			0
Substantive	2,813	1,410	(1,403)
Bank	748	630	(118)
Agency	365	566	201
Other	0	0	0
Total Pay	3,926	2,606	(1,320)
Non Pay	2,382	902	(1,480)
Reprofiled Plan	6,462	4,055	(2,407)

The table demonstrates delivery against the reprofiled plan in M8

- There is £1.3m slippage on pay related schemes
- There is £1.5m slippage on Non-Pay schemes
- The in-month £4.1m includes the reclassification of a previously reported mitigation of £0.6m relating to income.

Key Risks

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Key Risks

The Trust's financial plan for 2025/26 is **break-even,** including £43.3m deficit support funding (DSF). The key risks associated with delivery of the plan are closely monitored and reported monthly, they are:

- Full delivery of the **Waste Reduction Programme of £60.8m**.
- **Cash** flow forecasting is signalling cash will become a significant challenge by **Month 10 2025** and the Trust recently approved a Revenue Support PDC application to offset the DSF unpaid in M08 and at risk for the remainder of the financial year.
- **Divisional positions** to be within budget, and all pressures contained within the funding available in the plan.
- The financial impact of the **HCA review of banding** inclusive of the associated timescales for both cash and revenue. The prospective position still needs to be confirmed as ongoing payments are calculated.
- The financial impact of further **industrial action,** which continued in M09
- The impact of the **withholding of Deficit Support Funding** if the system/ Trusts are not delivering the financial plan. M8 DSF was withheld with the opportunity to earn this back. There is no confirmation for **Months 9-12.**
- The risk of an **Activity management plan (APM**) impacting ERF assumptions and overperformance of activity, which is to deliver the performance targets.
- There is an **emerging risk** around the value of stock in theatres, MIAA is currently reviewing this with an outcome due imminently.

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2025-26 Cashflow Forecast

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Cash Flow Forecast	M09	M10	M11	M12	M1	M2	M3	M4	M05	M06	M07	M08
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening Cash Balance	**14,977**	**3,654**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**
Cash Inflows												
Capital PDC funding	226	3,561	4,250	9,150	-	-	-	-	-	-	-	-
Other capital funding	2,032	2,032	2,032	2,716	2,000	2,000	2,000	2,000	2,000	2,000	2,000	2,000
Deficit Support Funding						-	-	-	-	-	-	-
Other ICB and NHSE income	64,691	64,738	68,344	64,054	72,500	72,500	72,500	72,500	72,500	72,500	72,500	72,500
Other NHS and non-NHS income	2,522	3,094	3,094	5,310	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
VAT	2,137	1,500	1,500	1,500	1,750	1,750	1,750	1,750	1,750	1,750	1,750	1,750
PDC revenue support	-	10,831	3,610	3,610	-	-	-	-	-	-	-	-
Interest	167	167	167	167	150	150	150	150	150	150	150	150
Total Inflows	**71,776**	**85,924**	**82,998**	**86,508**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**	**79,900**
Cash Outflows												
Capital Expenditure	(7,993)	(6,539)	(6,228)	(11,220)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Salaries	(33,019)	(31,939)	(31,994)	(30,405)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)	(31,000)
PAYE/NIC/Pension Benefits	(21,728)	(20,894)	(20,931)	(20,938)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)	(21,500)
NHS Litigation Authority Contributions	(2,624)	(2,624)	(0)	(0)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)	(2,400)
Other NHS Purchase Ledger Payments	(3,296)	(3,296)	(3,296)	(3,296)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)	(3,000)
Non-NHS Purchase Ledger Payments	(14,440)	(21,286)	(20,550)	(20,648)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)
Total Outflows	**(83,099)**	**(86,577)**	**(82,999)**	**(86,508)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**	**(79,900)**
Net Cash Flow	**(11,323)**	**(653)**	**(1)**	**1**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Closing Cash Balance	**3,654**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**	**3,000**

Key points and cash forecasting assumptions

- With Deficit Support Funding (DSF) not being awarded for November and December and the uncertainty over Q4 DSF that follows this decision, **the Trust has applied to receive £18.1m of Provider Revenue Support (PRS) PDC in Q4** to replace this shortfall with £10.8m requested for January.
- As previously reported, the Trust is having to be very proactive in managing its cash which means prioritising payments to suppliers on a daily basis and ensuring robust debt recovery is in place. This is now a critical part of the finance team's work given the withholding of DSF in month 8.
- With the latest YTD and risk adjusted forecast outturn deficit position, the shortfall on WRP delivery, as well as the risk to DSF in future months together with the impact of the payments to re-banded HCAs, the Trust will be reliant upon PRS PDC for 2025-26 to ensure treasury management can perform effectively.

Statement of Financial Position

	As at 31st March 2025 £000	As at 30th November 2025 £000	Year to date movement £000	Prior month £000	In-month movement £000
Assets:					
Intangible assets	19,168	17,996	(1,172)	18,278	(282)
Property, plant and equipment	266,094	265,597	(497)	264,873	724
Right of use assets	31,946	33,407	1,461	34,077	(670)
Inventories	11,310	11,537	227	11,368	169
Receivables (NHS)	17,592	23,787	6,195	22,338	1,449
Receivables (non-NHS)	19,605	22,218	2,613	23,660	(1,442)
Cash and cash equivalents	16,786	14,978	(1,808)	15,882	(904)
Total assets	382,501	389,520	7,019	390,476	(956)
Liabilities:					
Trade and other payables (capital)	(6,418)	(4,585)	1,833	(3,868)	(717)
Trade and other payables (non-capital)	(71,452)	(93,059)	(21,607)	(86,412)	(6,647)
Lease related liabilities	(32,433)	(34,220)	(1,787)	(34,849)	629
PFI related liabilities	(228,045)	(220,079)	7,966	(220,756)	677
Provisions for liabilities and charges	(3,439)	(3,461)	(22)	(3,458)	(3)
Other liabilities: deferred income	(13,693)	(11,900)	1,793	(14,613)	2,713
Total liabilities	(355,480)	(367,304)	(11,824)	(363,956)	(3,348)
Total assets employed	27,021	22,216	(4,805)	26,520	(4,304)
Financed by taxpayers equity					
Public dividend capital	332,933	337,681	4,748	337,073	608
Revaluation reserve	21,711	21,712	1	21,712	0
Income and expenditure reserve	(327,623)	(337,177)	(9,554)	(332,265)	(4,912)
Total taxpayers equity	27,021	22,216	(4,805)	26,520	(4,304)

The main in-month movement in the balance sheet is the £4.9m increase in the I&E reserve relating to the M08 deficit position before adjustments.

In addition, there has been a £2.7m reduction in deferred income, £1.6m of which relates to the M8 education funding for resident doctors received in M7 but released into the position in M8 with a further £0.7m relating to PFI funding received in March.

However, offsetting these movements is the £6.6m increase in non-capital payables.

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Capital Forecast	2025-26			M08			M09	M10	M11	M12	2025-26
	Initial Plan	Adjustments to Initial Plan	Revised Plan	Plan	Actual	Variance	Forecast	Forecast	Forecast	Forecast	Total
	£'000			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Internally Funded											
Donated Assets	500	1,725	2,225	336	44	-292	42	42	42	2,055	2,225
PFI lifecycle cost	3,604	2,086	5,690	2,400	3,793	1,393	474	474	474	475	5,690
CHO ROU assets	4,656	2,561	7,217	4,656	5,461	805	-	-	-	1,756	7,217
Other ROU asset (intra-DHSC group)	12	-	12	12	-	-12	-	-	-	12	12
Other ROU assets	6,332	-2,561	3,771	0	1,482	1,482	-	-	-	2,289	3,771
Other internally funded schemes	6,889	-3,506	3,383	4,576	2,653	-1,923	183	183	183	181	3,383
Externally funded											
UEC #2		2,225	2,225	-	280	280	0	494	700	751	2,225
Net Zero	1,980	-	1,980	-	963	963	500	517	-	-	1,980
Diagnostics	1,435	-	1,435	-	-	-	-	480	480	475	1,435
Elective Recovery	1,044	-	1,044	-	-	-	-	348	348	348	1,044
UEC	5,749	-2,783	2,966	-	-	-	-	989	989	988	2,966
Estates Safety	757	1,031	1,788	-	115	115	255	473	473	472	1,788
RAAC		4,279	4,279	-	378	378	357	357	357	2,830	4,279
Digital		710	710	-	223	223	-	-		487	710
Retinopathy pf Prematurity (ROP)		69	69	-	-	-	-	-		69	69
EPR (Oracle) to GP Connect integration		1,827	1,827	-	-	-	-	-		1,827	1,827
Funding to replace use of cash reserves		3,612	3,612	-	-	-	903	903	903	903	3,612
Total	**32,958**	**11,275**	**44,233**	**11,980**	**15,392**	**3,412**	**2,714**	**5,260**	**4,949**	**15,918**	**44,233**

Capital

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- The Trust's **Capital Programme for 2025/26 has increased by £2.2m to £44.2m** largely for an additional £1.8m PDC funded scheme.

- The Trust is yet to receive confirmation of funding for **£6.7m** of PDC funded schemes, although confirmation of £3.6m System Capital support is expected no later than January with the £2.4m of unconfirmed UEC funding the main area that is outstanding. Should some PDC funding not be approved relating to the impact of PFI, this will impact upon the Trust's internally funded capital programme to ensure investment is managed within internally generated funds (depreciation).

- The £11.0m included for right of use asset (ROU) related spend matches the allocation from the ICB has now been fully matched to specific schemes. Forecast spend on CHP leases is the main area of spend with these figures hopefully being finalised for M9, once lease renewals have been agreed. However, there is risk associated with the two highest value schemes where expenditure is yet to be recognised, namely the endoscopy scheme where discussions are ongoing to ensure that the contract is signed and equipment is replaced before year end and the £0.8m of equipment originally scheduled to be replaced in 2025/26 which has been pushed back due to the affordability of associated enabling works in the current financial year.

- Year to date, the Trust has recognised **£15.4m** of capital expenditure, consisting of **£6.9m of right of use assets related spend and £3.8m of PFI lifecycle related** spend with most of the remaining balance spent on Estates related schemes.

- This represents an overspend of **£3.4m against plan with the £2.3m of ROU asset and £1.4m of PFI lifecycle spend recognised ahead of plan** offsetting slippage elsewhere.

Glossary

Better Payment Practice Code (BPPC) - *The requirement of the BPPC is to pay 95% of undisputed, valid invoices within 30 days of receipt. The 95% is in terms of value and volume of invoices.*

Deficit Support Funding (DSF) - *Non recurrent funding to allow trusts to deliver a breakeven position in 2024-25*

Elective Recovery Fund (ERF) – *Additional funding received by the trust to deliver 107% of pre-pandemic elective activity (elective activity being outpatient new, outpatient procedures, day cases and electives).*

Goods Received Not Invoiced (GRNI) - *refers to a situation where the trust has received goods but hasn't yet received the corresponding invoice from the supplier, necessitating a temporary accounting entry to track the liability until the invoice arrives.*

IFRS – *International Financial Reporting Standards constitute a standardised way of describing Trusts/company's financial performance and position so that company financial statements are understandable and comparable across international boundaries.*

IFRS16 Right of Use Assets – *Following the change in accounting standards, the trust must recognise and capitalise the appropriate leases through the balance sheet, where previously is was recognised through revenue only.*

Glossary

PDC Public Dividend Capital *represents the Department of Health's (DH's) form of funding to NHS Providers. The DH is expected to make a return on its net assets, including the assets of NHS trusts, of 3.5%.*

PDC Provider Revenue Support *- Revenue Support PDC is available to support revenue expenditure for cash-distressed providers for necessary and essential expenditure to protect continuity of patient services* **Waste Reduction & Finance Improvement Programme** (WR & FIP) – this is the terminology for the efficiencies required by the trust. (previously referred to as CIP / WRP) Waste Reduction is achieved when the actual run rate is reduced

Run Rate – Refers to the income and expenditure trend for an organisation at the end of a defined financial period. In this case we use the NHS financial year (24/25 Inflated for 25/26 prices)

Normalised Run rate - The Normalised Run rate removes any non-recurrent pressures/benefits , any technical gains and any rephasing of income or expenditure such as pay awards to the month it relates to.

Exit Run Rate - Recurrent run rate income and expenditure trend for an organisation at the end of a defined financial period. In this case we use the NHS financial year, and the exit run rate is defined by the position on 31 March 2025 excluding non-recurrent income/expenditure and the full year effect of income/expenditure.

Provider Financial Return (PFR) – Monthly financial monitoring NHSE return

Financial Planning Return (FPR) – The yearly financial plan template set out by NHSE.

Waste Reduction Programme (WRP) – The Trusts efficiency programme

High-Cost Drugs (HCD) – High-cost drugs are pass through in nature

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TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/010
Report Title:	Integrated Performance Report		
Author:	Stephen Dobson		
Lead Director:	Sharon Gilligan		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	x	x		x
Executive Summary:	The Board are directed towards the following sections: • **Safe** • **Responsive** • **Well Led**			
Key Issues/Areas of Concern:	The Board are directed towards the following issues of concern: **Safe** • Staffing Overall RN fill rates: Days 91.31%, Nights 97.69%. 19 clinical areas below 90% **Responsive** • One 65-week RTT breach occurred on the final day of the month due to a communication failure; this has been investigated and learning actions are in place. • 12-hour ED waits improved in-month but remain a significant pressure. • Bed occupancy remains consistently high (>95%), limiting flow and contributing to UEC challenges. **Well Led – Finance** • Month 8 deficit of £5.9m (excluding DSF), £3.2m behind plan. • In-Month WRP delivered of £3.5m, £2.5m behind plan • WRP delivery of £25.5m year-to-date, £10.8m adverse to plan			
Action Required by the Committee:	Directors are requested to note the attached report for assurance.			

Previously Considered by:	
Date:	
Outcome:	

Integrated Performance Report

Published: December 2025

Safe | Personal | Effective

NHS
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Contents

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How to read an SPC Chart

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Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart
The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation
Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.
The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:
• a point beyond the process limits
• a run of points all above or all below the mean
• a run of points all increasing or all decreasing
• two out of three points close to a process limit as an early warning indicator

Summary

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The matrix provides a summary of performance metrics included in this report. It highlights where metrics are showing assurance and variation.
19% of our metrics are consistently achieving target
34% of our metrics are inconsistently achieving target
15% of our metrics are not achieving target, however 5 of these are showing special cause improvement.
32% of our metrics do not have a target currently set.

Assurance

Variation	Achieving target	Inconsistently achieving target	Not achieving target	No target set
Special cause improvement	Turnover	Maternity F&F, A&E 4hr, 31d cancer, Vacancy	VTE, RTT % >52wks, RTT < 18wks treatment, <18wks for 1st appt, Appraisal (AFC)	Cancelled on day ops, Income run rate, Avg arrival to handover, Maximum arrival to handover
Common cause	Avg fill care staff (day & night), Inpatient, Community, Outpatient F&F, Appraisal (consultant & other medical), Safeguarding children training	Avg fill RN (day), MRSA, 28d cancer, 62d cancer, Cancelled on day not rebooked in 28d, Variance to planned performance, WRP, BPPC x 1, Variance to capital programme	Wards <90% RN day fill, A&E F&F, Sickness	Crude Mortality rate, In hospital deaths, Stillbirths, C diff, E coli, Pseudomonas, Klebsiella, 62d urgent cancer GP, Emg avg LOS, % occupied 7+, 14+ & 21+
Special cause concern	Avg fill RN (night), Complaints, Agency spend	CHPPD, Nursing red flags, Over 12hr TiD % (type 1), BPPC x 3, Liquidity days	IG training	A&E Attendances, Bed occupancy, % handovers >30 mins, Handovers > 45 mins, Employee expenses run rate, Other operating run rate

SAFE - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
AVERAGE FILL RATE REGISTERED CARE STAFF (DAY)	NOV 25	95.27	90.00		P
AVERAGE FILL RATE REGISTERED CARE STAFF (NIGHT)	NOV 25	109.60	90.00		P
AVERAGE FILL RATE REGISTERED NURSES (DAY)	NOV 25	91.31	90.00		?
AVERAGE FILL RATE REGISTERED NURSES (NIGHT)	NOV 25	97.69	90.00	L	P
MRSA	NOV 25	0.00	0.00		?
PATIENTS RISK ASSESSED FOR VENOUS THROMBOEMBOLISM	NOV 25	90.46	95.00	H	F
CARE HOURS PER PATIENT DAY (CHPPD)	NOV 25	7.76	8.00	L	?
NATIONAL NURSING RED FLAGS	NOV-25	15.00	0.00	H	?
WARDS <90% REGISTERED NURSE (DAY) FILL RATE	NOV-25	18.00	0.00		F

METRIC	LATEST DATE	VALUE	VARIATION
REGISTERED NURSE AGENCY SPEND	NOV 25	45778.78	L
REGISTERED NURSE BANK SPEND	NOV 25	1013467.03	L
MEDICATION ERRORS CAUSING LOW HARM AND ABOVE	NOV 25	39.00	L
SLIPS TRIPS AND FALLS CAUSING LOW HARM AND ABOVE	NOV 25	67.00	

Alert

During November 2025 overall Nurse staffing was achieved at trajectory for RN and Care Support workers.
19 clinical areas were below the fill rate of 90% for the month of November 2025 during day shifts. Of which 2 ward fell below 80% fill rate, this relates to unexpected unavailability and movement of co-ordinators.
1 clinical areas were below the fill rate of 90% for the month of December 2025 during night shifts in the Family Care Division. These were all due to unexpected unavailability.
Nursing red flags for November 2025 was 15, due to delays in intentional rounding and delay of more than 30 mins in providing pain relief.. There were no patient harm as a result for this but could result in poor patient experience.
Midwifery National NICE red flags for September 2025 was 17.

Advise

Nurse staffing continues to be monitored twice daily in a trust wide staffing meetings chaired by Divisional Directors of Nursing.
Midwifery staffing continues to be monitored four times a day. Where pressure are increased, the calls are then attended by each Divisional Director of Nursing and 1 Deputy Chief Nurse.
The number of reported pressure ulcer incidents decreased from 70 in October to 56 in November. The number of Moisture-Associated Skin Damage (MASD) incidents remained stable during the same period.
Q2 Assessment and Documentation of Pressure Ulcers audit results increased from 50% in Q1 to 58% Q2 which remains below the target range of 70–85%. Staff have been reminded of the importance of completing all relevant risk assessments within four hours of patient admission.

Assurance

During November 2025 overall Nurse staffing was achieved at or above trajectory for RN and Care Support workers.
The overall percentage fill rate for RNs for days was 91.31% and nights was 97.69%. The overall percentage fill rate for CSW for days was 98.59% and nights was 110%.
Compliance with Pressure Ulcer (90.2%) and Moisture-Associated Damage (90.5%) e-learning remains moderately high. This is continually by the Pressure Ulcer Steering Group to support sustained improvement and ongoing staff education.

SAFE - Infection Control

East Lancashire Hospitals NHS Trust
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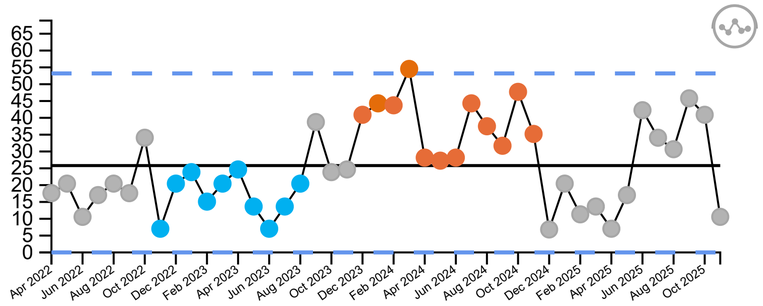
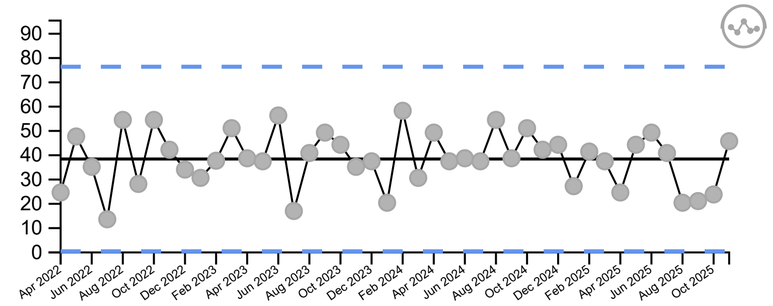
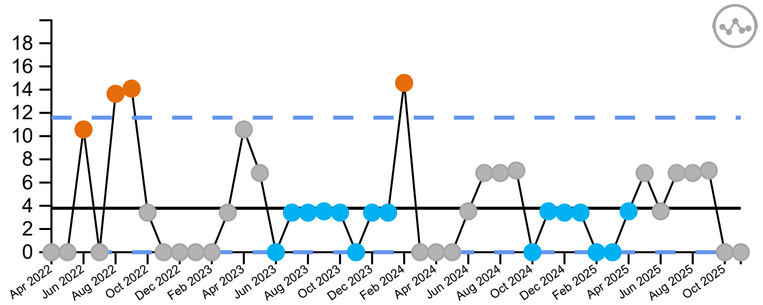
C diff per 100000 bed days rate



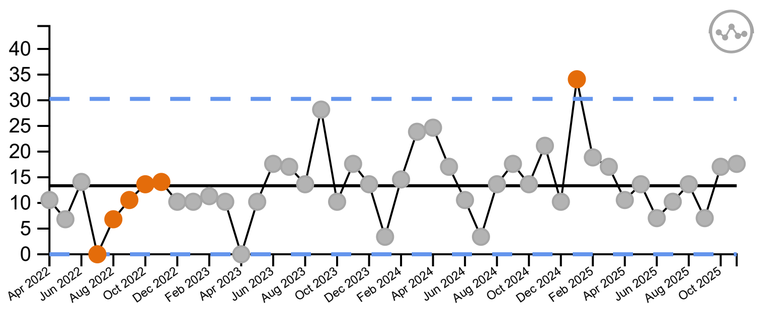
Ecoli per 100000 bed days rate



Pseudomonas per 100000 bed days rate



Klebsiella per 100000 bed days rate



C diff

In month	YTD	Same time last year
4	67	48

E coli

In month	YTD	Same time last year
(Blank)	65	63

Klebsiella

In month	YTD	Same time last year
(Blank)	23	20

Pseudomonas

In month	YTD	Same time last year
(Blank)	10	5

MRSA

In month	YTD	Same time last year
0	2	1

SAFE - Staffing

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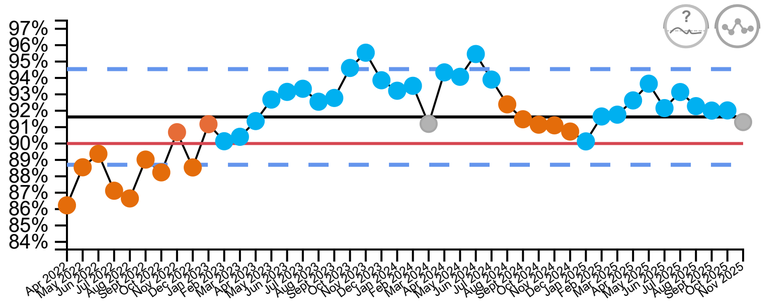
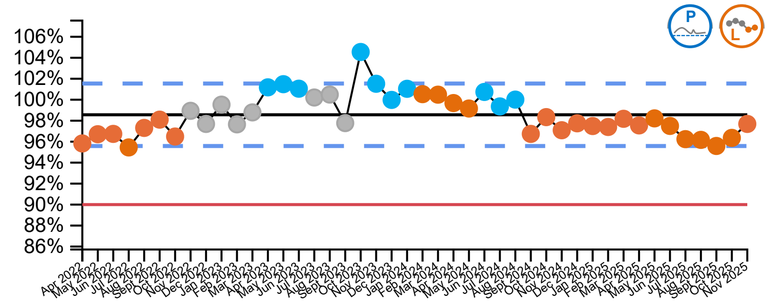
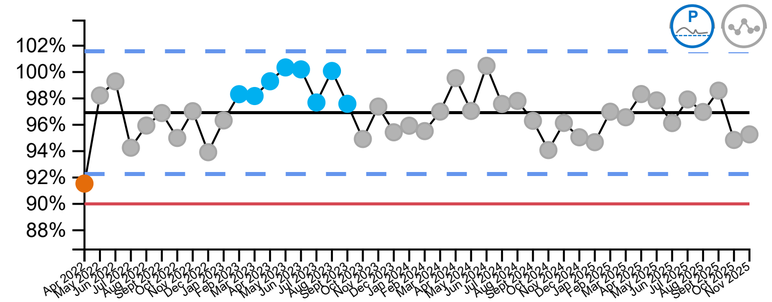
Average fill rate registered nurses (day)



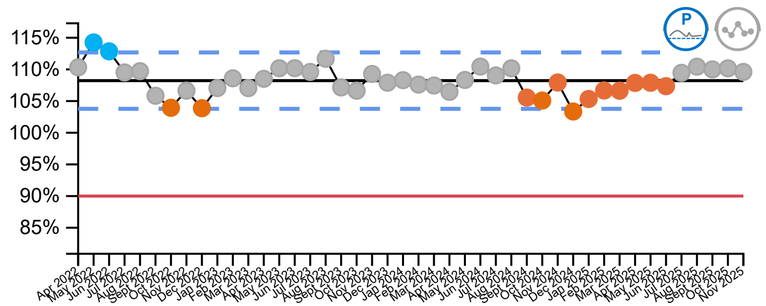
Average fill rate registered nurses (night)



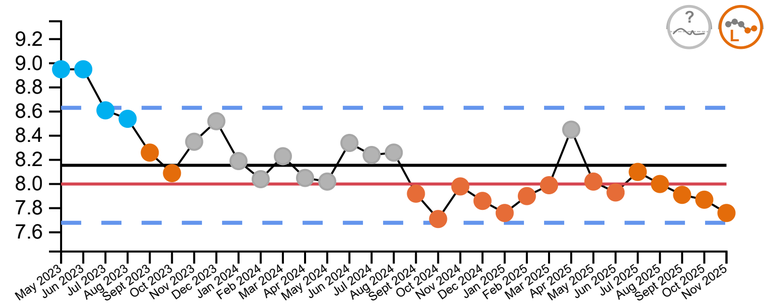
Average fill rate registered care staff (day)



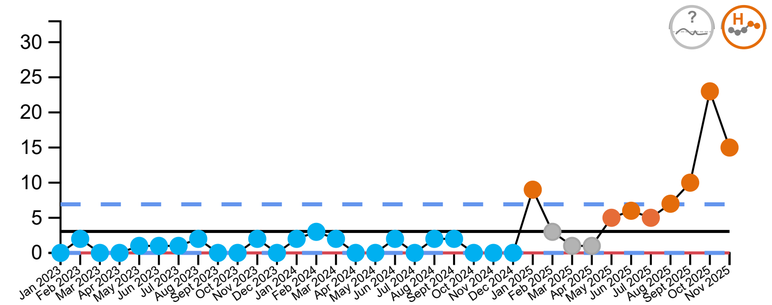
Average fill rate registered care staff (night)



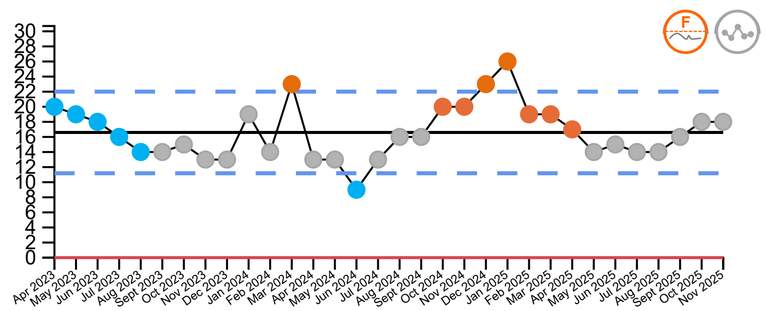
Care hours per patient day (CHPPD)



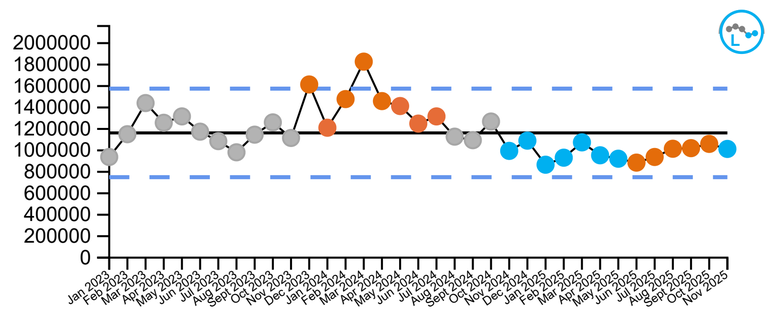
National nursing red flags



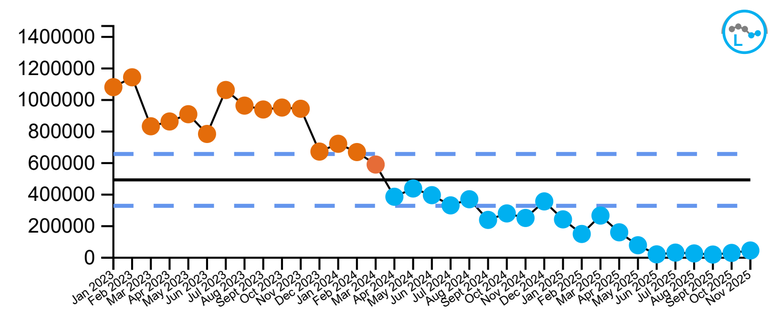
Wards <90% registered nurse (day) fill rate



Registered nurse bank spend



Registered nurse agency spend



SAFE - Incidents and Pressure Ulcers

East Lancashire Hospitals NHS Trust
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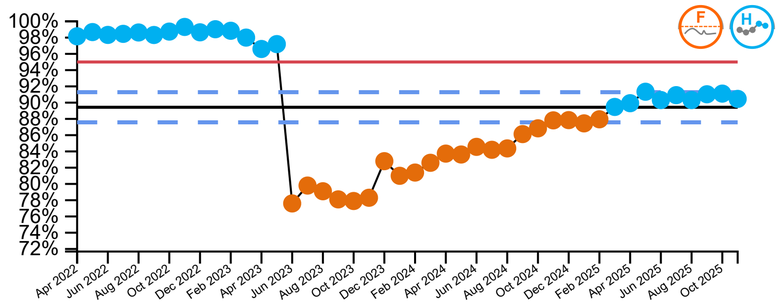
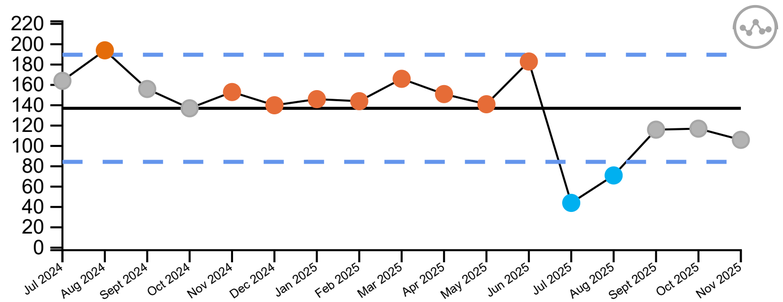
	Never events	Serious incidents reported to PSIRF	Medication errors moderate harm and above	Slips trips falls moderate harm or above	
In month >	0	3	2	1	
YTD >	2	24	15	23	CAS alerts - Non-compliance: 1

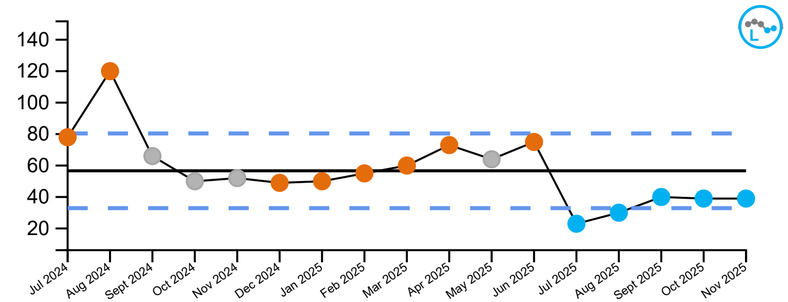
Patients risk assessed for Venous Thromboembolism



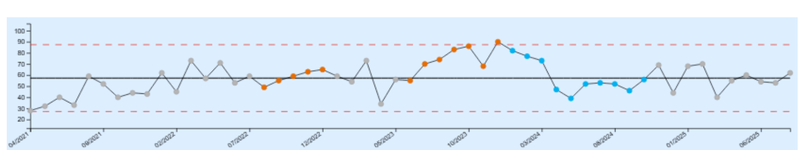
Medication errors causing low harm and above



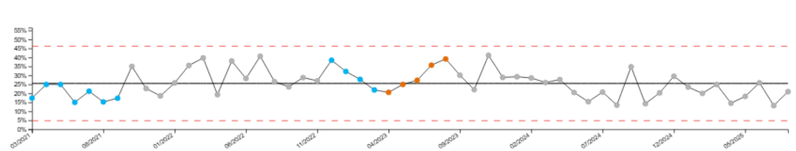
Medication errors causing low harm and above



Total pressure ulcers developed in ELHT



Total pressure ulcers with lapses in care



A number of pressure ulcers in recent months remain currently under investigation. New reporting definitions were also introduced from April 2024.

CARING - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
A&E FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	NOV 25	69.06	90.00		F
COMMUNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	NOV 25	94.70	90.00		P
COMPLAINTS RATE PER 1000 CONTACTS	NOV 25	0.22	0.40	H	P
INPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	NOV 25	96.66	90.00		P
MATERNITY FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	NOV 25	92.86	90.00	H	?
OUTPATIENT FRIENDS AND FAMILY % DESCRIBING THEIR EXPERIENCE AS GOOD OR VERY GOOD	NOV 25	94.28	90.00		P

Alert

The A&E Friends & Family Test (FFT) positive score is 69%, with Negative responses at 21%. While the positive score remains static and is currently below the recent performance range of 70%+, the result remains relatively close to the national average of 77% positive and 15% negative, especially considering the current operational pressures faced by the department. However, A&E performance remains a concern and continues to require targeted intervention and close monitoring.
The majority of negative feedback relates to waiting times. Other negative themes included pain and emotional and physical support. Within the theme of waiting, most of the negative comments related to results and treatment.

Advise

Complaints remain within acceptable limits at 0.22 (per thousand contacts), performing significantly below the internal threshold of 0.40. However, despite fluctuating volumes during the reporting period, timeliness in case resolution has declined, currently averaging 65 days. It is important to note that the Trust places significant emphasis on the quality of the response. The quality assurance process can at times mean that a complaint may take longer to conclude that anticipated by the Trust. The oversight and management of complaints continue to be monitored through weekly collaborations between the Customer Relations Team and Divisions.

Assurance

All other Friends & Family Test (FFT) results, covering Community, Inpatient, Maternity, and Outpatient services, provide strong Assurance status. These results consistently exceed their respective ALT Targets, reflecting exceptionally high levels of patient satisfaction across the majority of the Trust's services.

CARING - Feedback

East Lancashire Hospitals NHS Trust
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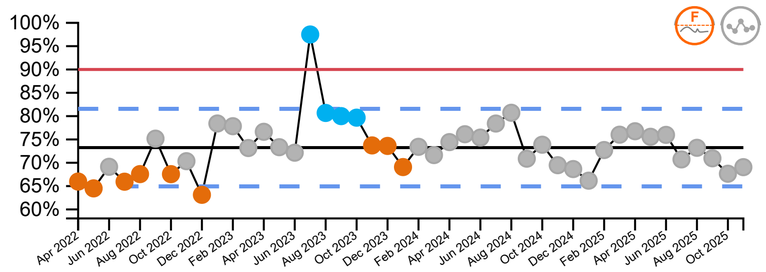
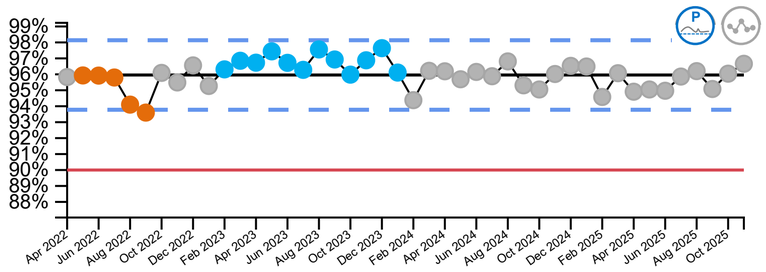
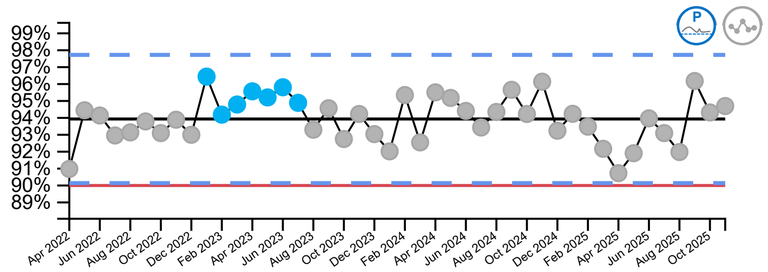
A&E Friends and Family % describing their experience as good or very good



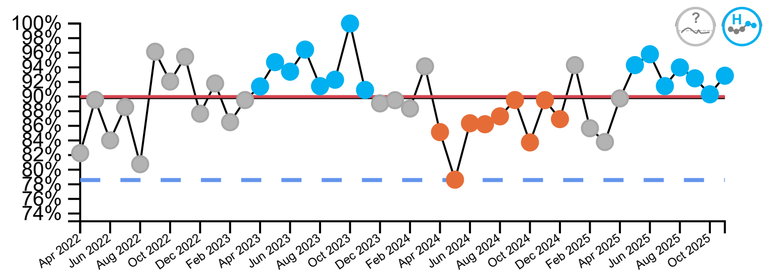
Inpatient Friends and Family % describing their experience as good or very good



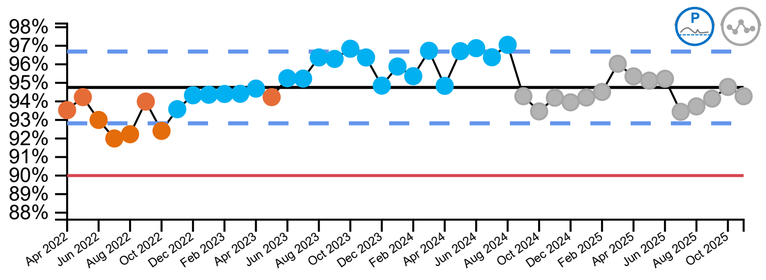
Community Friends and Family % describing their experience as good or very good



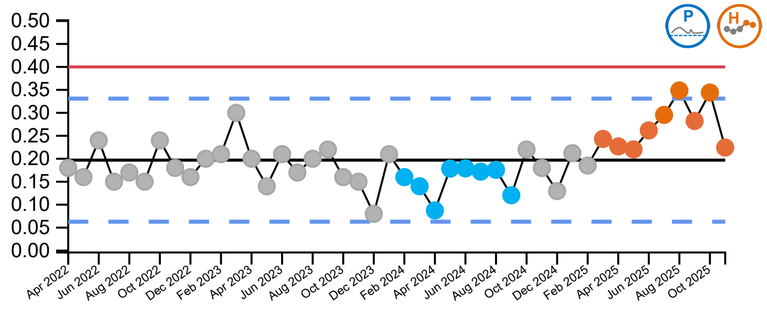
Maternity Friends and Family % describing their experience as good or very good



Outpatient Friends and Family % describing their experience as good or very good



Complaints rate per 1000 contacts



EFFECTIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	VARIATION
CRUDE DEATHS	NOV 25	129.00	
CRUDE MORTALITY RATE	NOV 25	2.94	
STILLBIRTHS	NOV 25	1.00	

METRIC	LATEST DATE	VALUE
MATERNAL DEATHS	NOV 25	0.00
SHMI	JUN 25	1.23
HOSPITAL STANDARDISED MORTALITY RATIO	AUG 25	103.60

Alert

The Trust remains unable to provide full assurance in relation to the HSMR and SHMI mortality indicators due to issues with data submission and the impact of inconsistent removal of SDEC activity across NHS Trusts.
Current SHMI is 1.23, which is above expected. As expected the decrease seen over the last 12 months related to the elimination of uncoded data has now plateaued, and this month there has been a slight increase. Current HSMR+ is 103.6, which is within expected, as it also was for the previous month. This also has increased slightly against the previous month.

Advise

The most recent HSMR+ and SHMI figures now include a full 12 months of coded data, and therefore the issue relating to incomplete diagnostic codes impacting our SHMI has resolved, and the HSMR+ figure which has previously only included the coded months will now represent a 12 month rolling period.
Work is ongoing to improve the throughput of SJR reviews. The administration post has been filled, and additional reviewers have been trained, although there have been retirements of experienced reviewers. Throughput does remain below target. Work continues to incorporate local directorate mortality review processes.

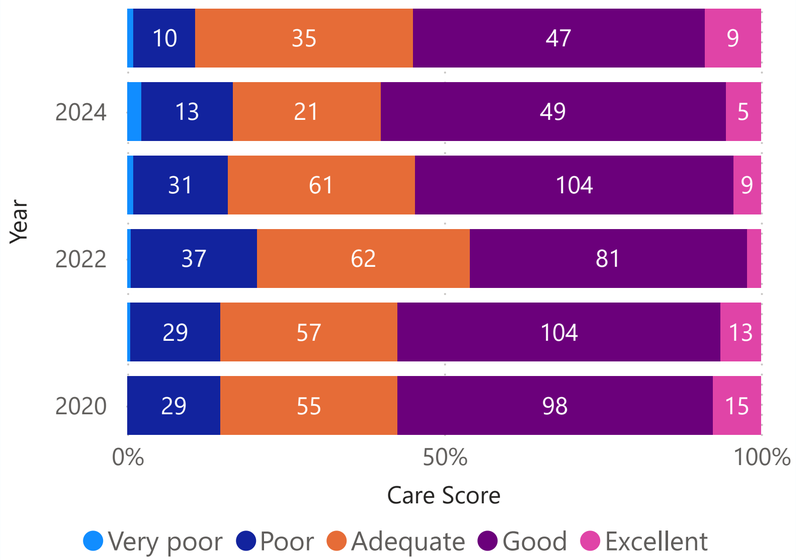
Assurance

Some assurance with respect to trust mortality is provided by close monitoring of the crude mortality rate, which does not exceed control limits.

EFFECTIVE - Mortality

East Lancashire Hospitals NHS Trust
A University Teaching Trust

SJR Stage 1 Completed by Year and Overall Score



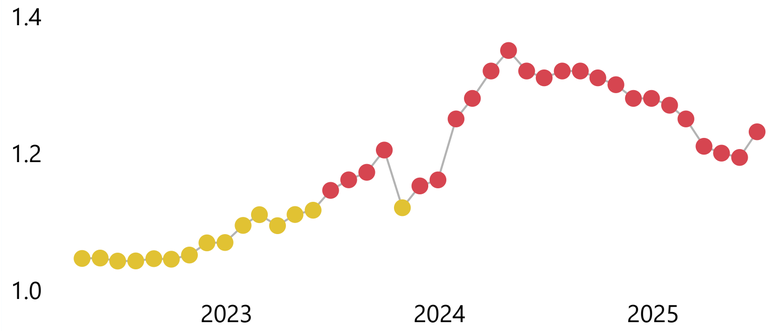
SHMI and HSMR Series

Below expected levels
Within expected levels
Higher than expected levels

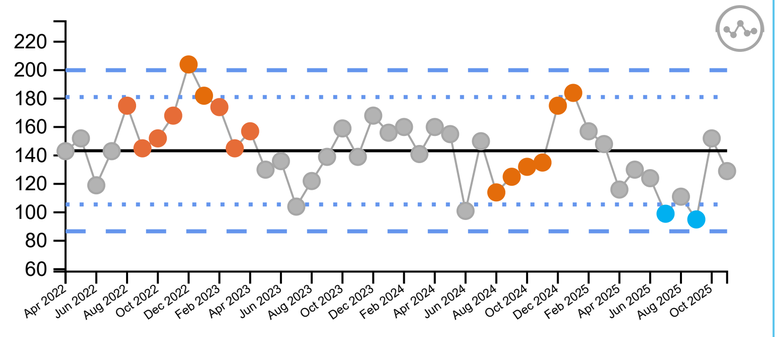
Learning Disability Mortality Reviews

There have been 3 deaths in November all for whom have been referred to LeDeR. 3 deaths were reviewed this month, 1 outstanding for completion awaiting outcome of SJR2.

SHMI



In Hospital Deaths



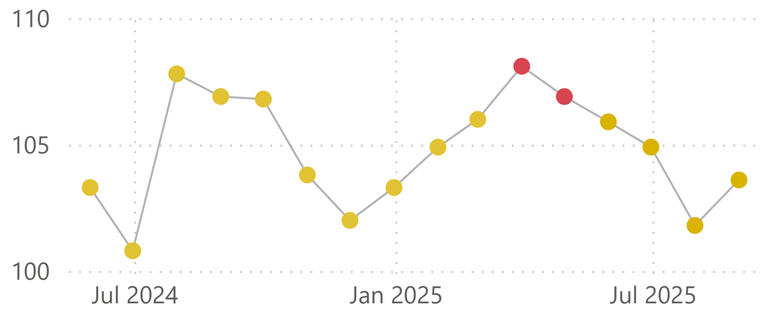
Stillbirths

In month	YTD	Same time last year
1	19	11

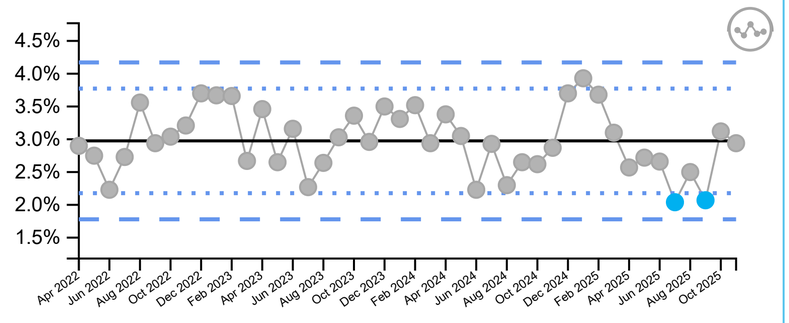
Maternal deaths

In month	YTD	Same time last year
0	1	1

Hospital Standardised Mortality Ratio (rolling monthly)



Crude mortality rate



RESPONSIVE - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
28D GENERAL FDS	OCT 2025	78.40	80.00		
62D GENERAL STANDARD	OCT 2025	73.00	75.00		
A&E 4HR PERFORMANCE (TRUST)	NOV 2025	78.51	78.00		
DM01 % OVER 6 WEEKS	NOV 2025	1.54	5.00		
NOT TREATED WITHIN 28 DAYS OF LAST MINUTE CANC	NOV 2025	4.00	0.00		
RTT ONGOING % OVER 52 WEEKS	NOV 2025	2.38	1.00		
RTT ONGOING % UNDER 18 WEEKS	NOV 2025	60.74	62.00		

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
OVER 12 HOURS IN DEPARTMENT %	NOV 25	15.35	15.20		

METRIC	LATEST DATE	VALUE	VARIATION
A&E ATTENDANCES	NOV 25	24886.00	
BED OCCUPANCY G&A	NOV 25	95.38	
CANCELLED ON DAY OPERATIONS	NOV 25	42.00	
EMERGENCY AVERAGE LENGTH OF STAY (EXCL 0 AND 1 DAYS)	NOV 25	10.62	
PATIENTS OVER 62 DAYS (URGENT GP REFERRAL)	NOV 25	298.00	
% HANDOVERS > 30 MINUTES	NOV 25	14.66	
AMBULANCE HANDOVERS >45 MINUTES	NOV 25	82.00	

METRIC	LATEST DATE	VALUE	VARIATION
MAX ARRIVAL TO HANDOVER TIME	NOV 25	92	
AVERAGE ARRIVAL TO HANDOVER	NOV 25	22	

METRIC	LATEST DATE	VALUE
RTT ONGOING	NOV 25	52322.00
RTT OVER 52 WEEKS	NOV 25	1186.00
RTT OVER 65 WEEKS	NOV 25	1.00

Alert

RTT 65 Weeks - One 65-week RTT breach occurred on the final day of the month, attributable to a communication breakdown between ward and theatre teams. The patient has since received treatment. An IR1 has been completed, and learning actions are being identified to prevent recurrence, with a particular focus on strengthening end-to-end communication and escalation processes.

Urgent and Emergency Care – 12-Hour Stays - Performance for patients spending over 12 hours in the Emergency Department showed improvement in November at 15.4%, representing a 0.87% improvement compared to October. Despite this progress, the Trust continues to face challenges in reducing 12-hour stays.

Improvement activity remains ongoing through the Urgent and Emergency Care (UEC) improvement programme, including the operationalisation of the Medical Decisions Unit and Professional Standards within the medical workforce.

Advise

Ambulance Handover Delays (>45 minutes) - There were 82 breaches in November, a reduction of 38 compared to October. This improvement reflects sustained collaborative working between the Trust and Northwest Ambulance Service (NWAS), alongside internal operational actions to improve patient flow and handover processes.

Bed Occupancy - Bed occupancy remains consistently high at 95.38%, reflecting ongoing inpatient demand and continued flow pressures across the system. Work continues to focus on optimising discharge processes, improving internal flow, and strengthening system working to mitigate capacity challenges.

Assurance

Referral to Treatment (RTT)

- Total RTT on-going: 52,322 – below the trajectory of 54,516
- 52-week waits: 1,186 – below the trajectory of 1,639 (2.4% vs trajectory of 3%; target 1% by March 2026)
- <18 weeks: 60.74% – above trajectory of 60.3% (target 62.2% by March 2026)
- First outpatient waiting <18 weeks: 65.2% – above trajectory of 64% (target 67% by March 2026)

Cancer Performance

- Faster Diagnosis Standard (FDS): Improved to 78.4%, above trajectory (target 80% by March 2026)
- 62-Day Standard: 73%, delivering against trajectory (target 75% by March 2026)

Diagnostics (DM01) - Performance for November was 1.54%, meaning 98.46% of patients received their diagnostic test within six weeks, demonstrating strong and sustained compliance.

Urgent and Emergency Care 4-Hour Standard - 78.51%, exceeding the national ambition of 78% by March 2026

Ambulance Handover Performance

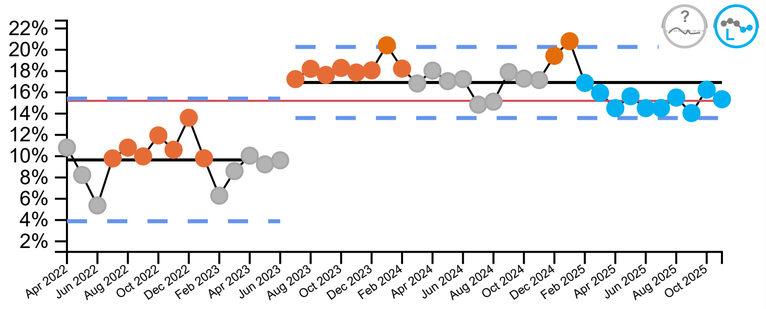
- Average handover time: 00:21:48 – below trajectory of 00:23:38 and improved from 00:26:05 in the previous year
- Average NWAS handover time: 00:27:58

Patients handed over within 30 minutes: 83.63%, an improvement of 1.7% compared to October

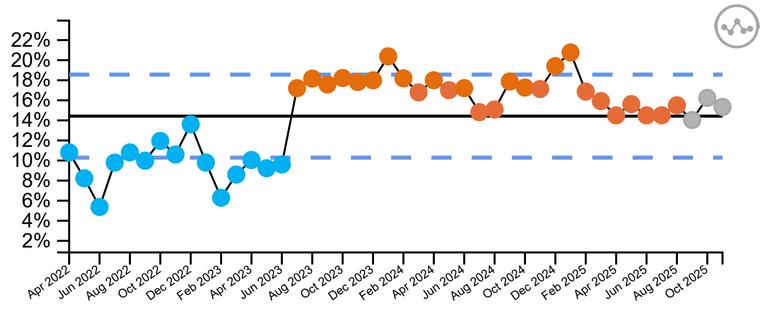
RESPONSIVE - A&E

East Lancashire Hospitals NHS Trust
A University Teaching Trust

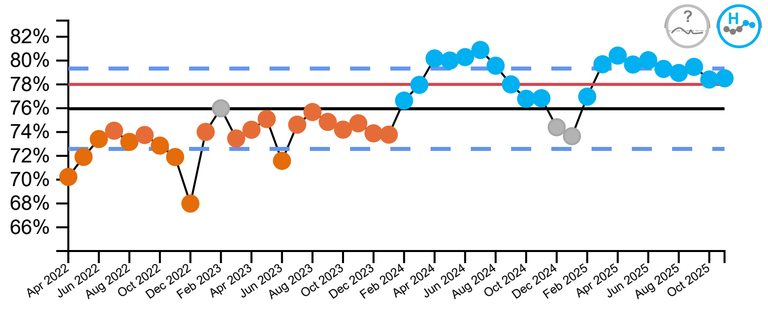
Over 12 hours in department % (type 1)



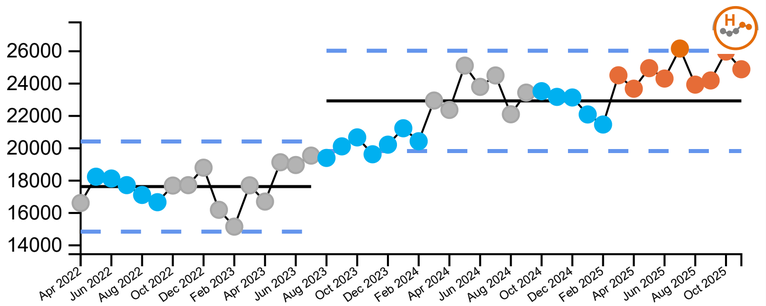
Over 12 hours in department %



A&E 4hr Performance (Trust)



A&E Attendances



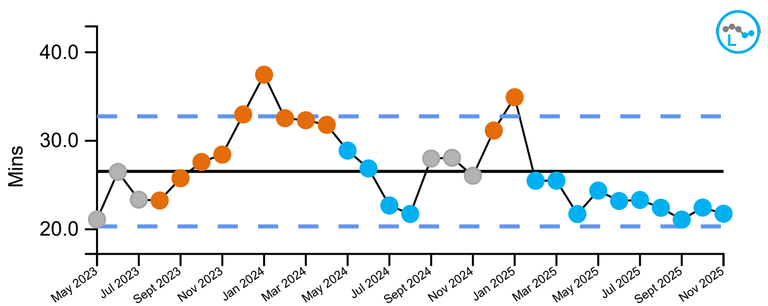
Average arrival to handover time (mins) (latest month)

22

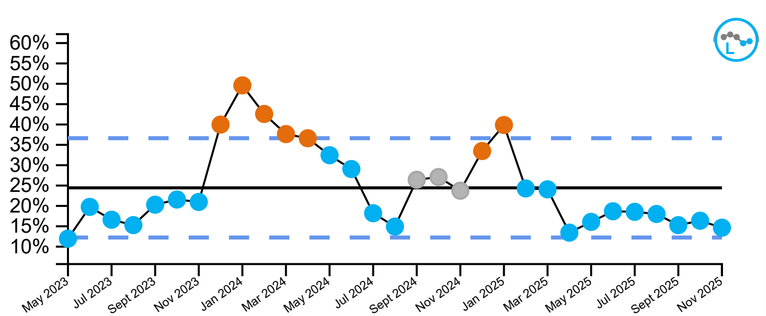
Maximum arrival to handover time (mins) (latest month)

92

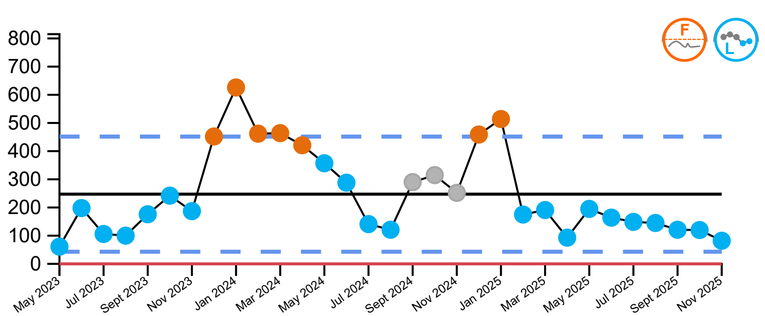
Average arrival to handover



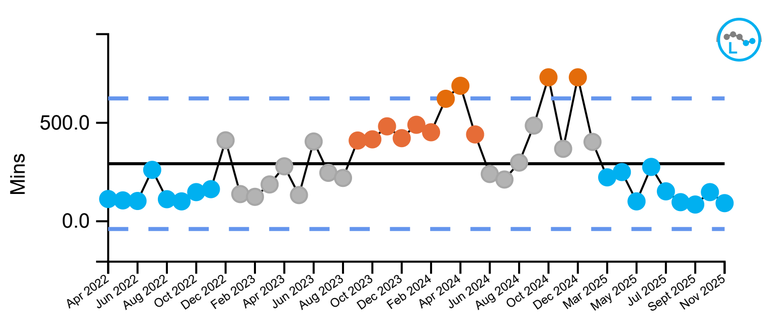
% handovers > 30 minutes



Ambulance Handovers >45 minutes



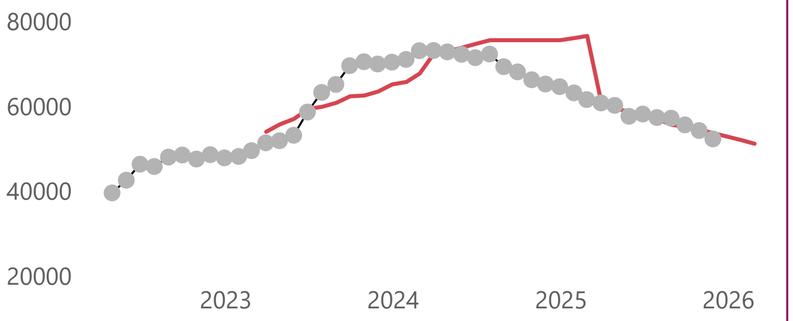
Max arrival to handover time



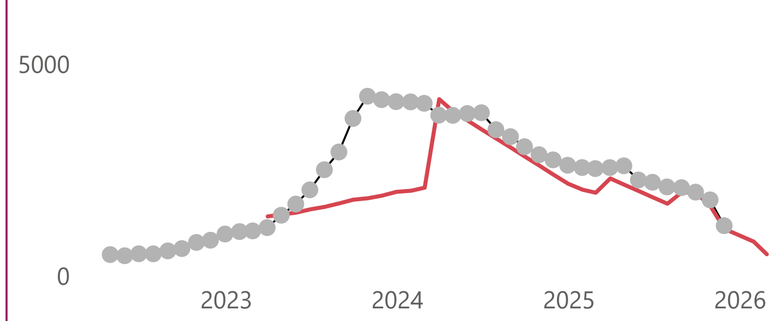
RESPONSIVE - RTT and Diagnostics

East Lancashire Hospitals NHS Trust
A University Teaching Trust

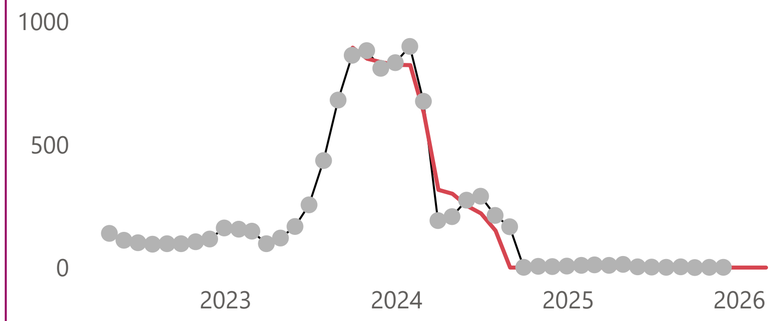
RTT Ongoing



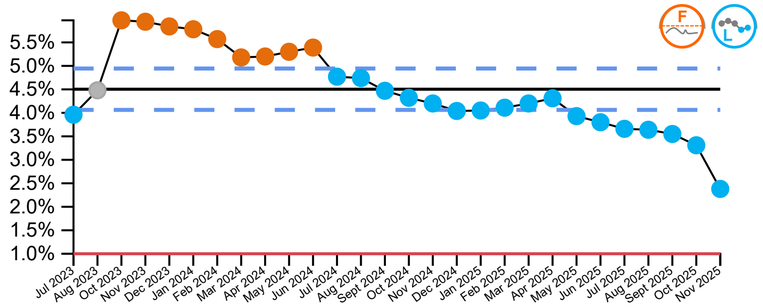
RTT Over 52 Weeks



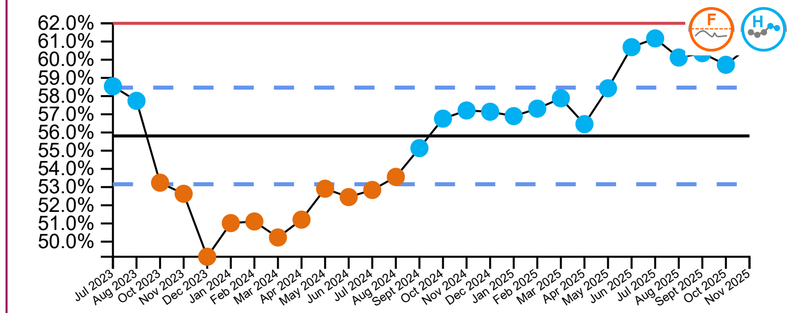
RTT Over 65 Weeks



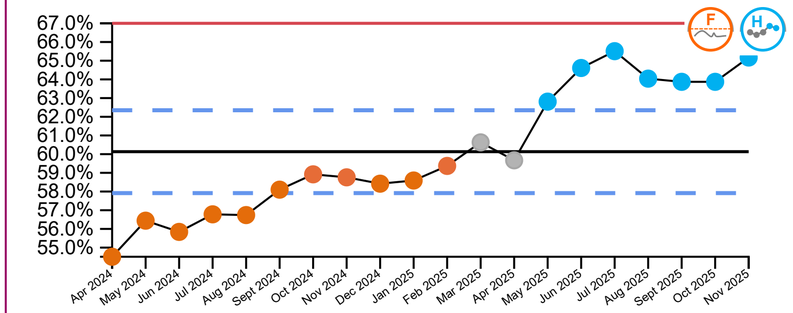
RTT Ongoing % Over 52 weeks



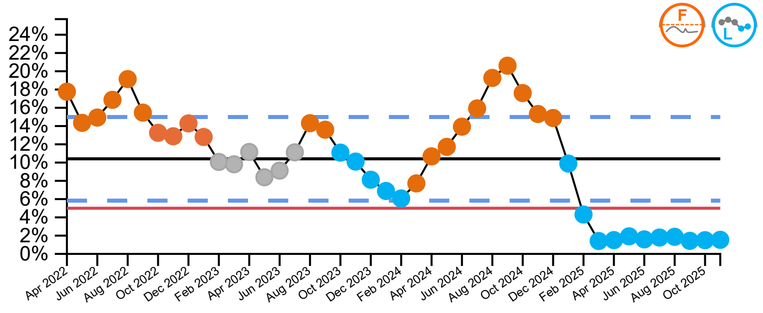
Proportion waiting < 18 weeks for treatment



Proportion waiting < 18 weeks for 1st appointment



DM01 % over 6 weeks

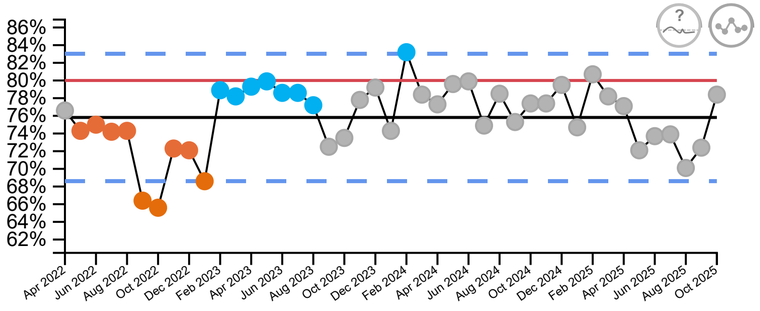


Safe | Personal | Effective

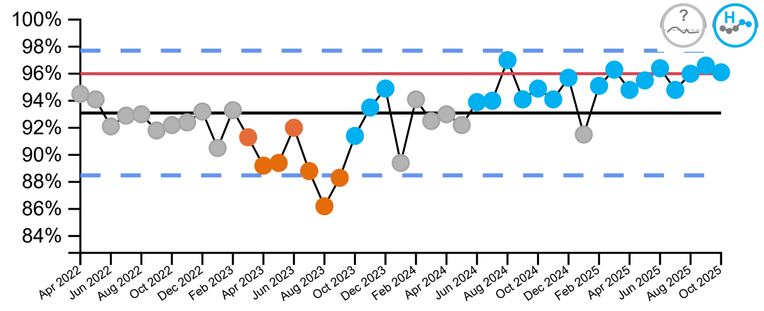
RESPONSIVE - Cancer

East Lancashire Hospitals NHS Trust
A University Teaching Trust

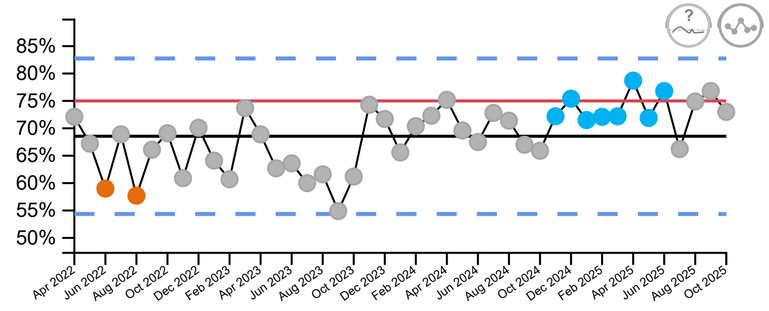
28d General FDS



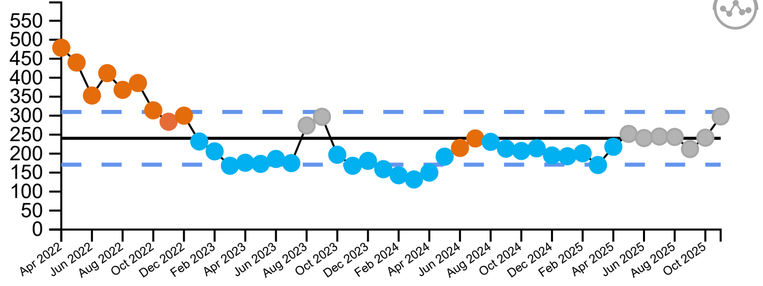
31d General treatment standard



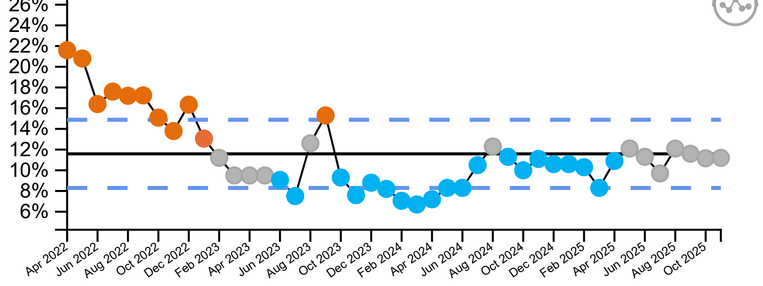
62d General Standard



Patients over 62 days (urgent GP referral)



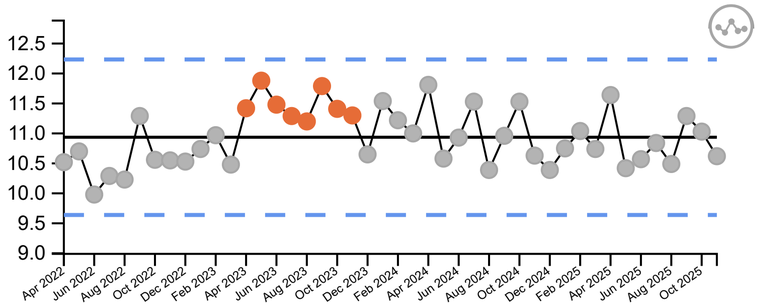
Waiting over 62 days (urgent GP referral)



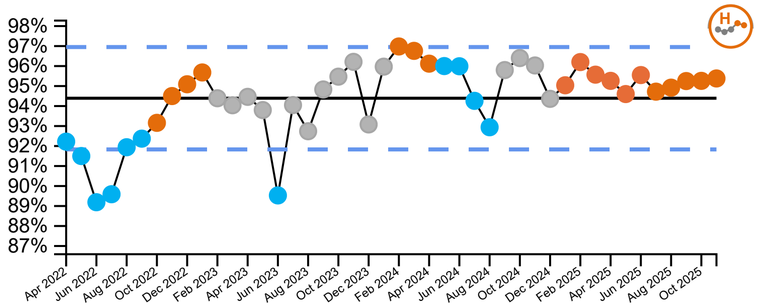
RESPONSIVE - Length of Stay and Bed Occupancy

East Lancashire Hospitals NHS Trust
A University Teaching Trust

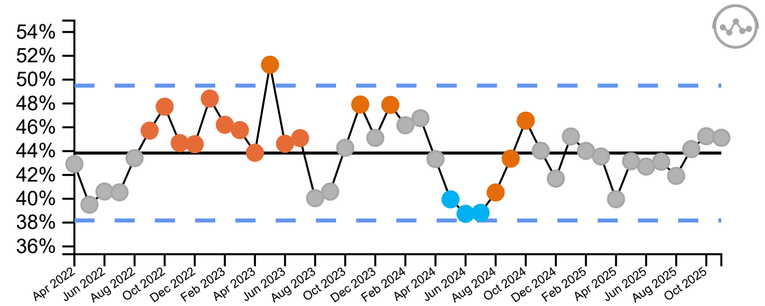
Emergency average length of stay (excl 0 and 1 days)



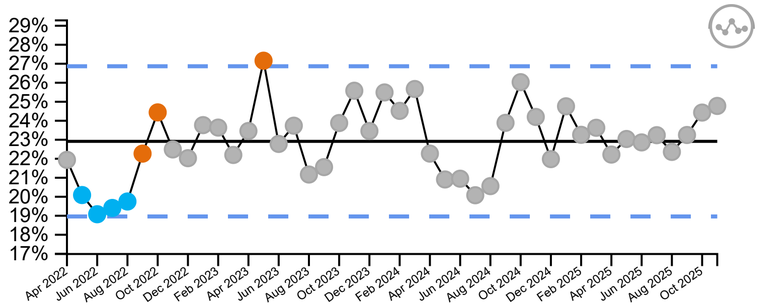
Bed occupancy G&A



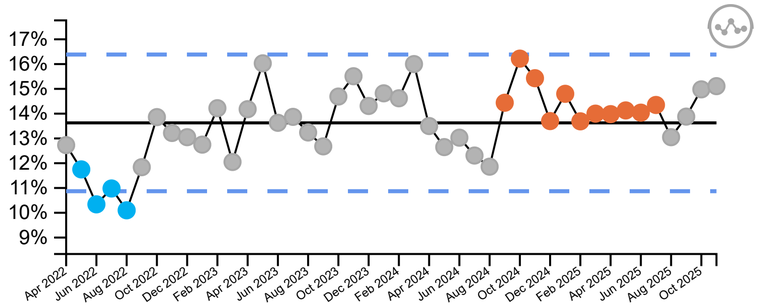
% Beds occupied by Long-Stay Patients 7+ days



% Beds occupied by Long-stay patients: 14+ days



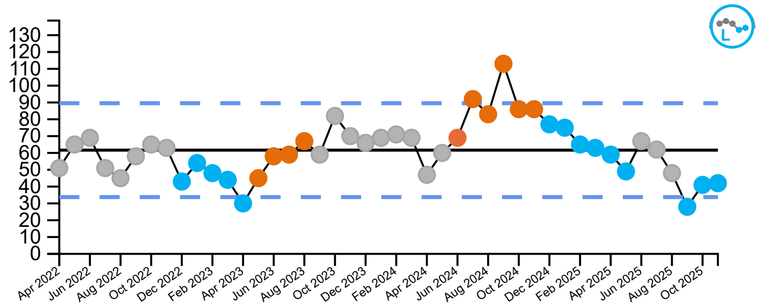
% Beds occupied by Long-stay patients 21+ days



RESPONSIVE - Cancellations and Utilisation

East Lancashire Hospitals NHS Trust
A University Teaching Trust

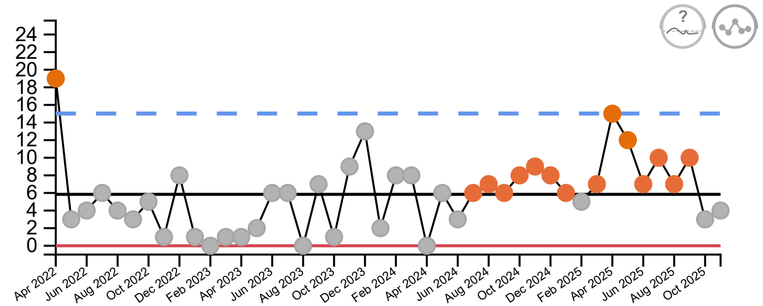
Cancelled on day operations



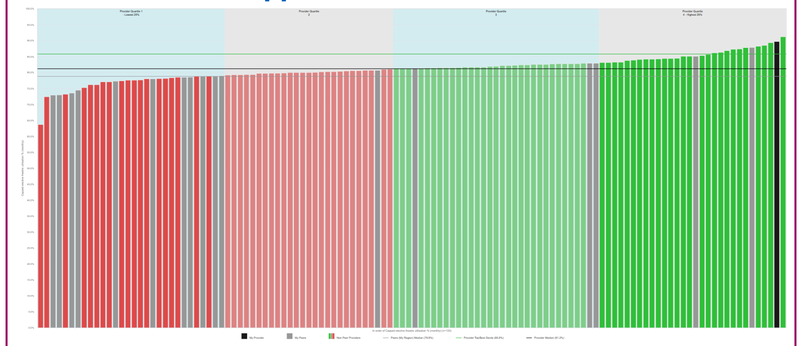
Urgent operations cancelled for 2nd time

0

On the day cancelled operations not rebooked in 28 days



Capped theatre utilisation



WELL LED - Summary Scorecard

East Lancashire Hospitals NHS Trust
A University Teaching Trust

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
APPRAISAL (AGENDA FOR CHANGE)	NOV 25	79.00	90.00	H	F
APPRAISAL (CONSULTANT)	NOV 25	96.00	90.00		P
APPRIASAL (OTHER MEDICAL)	NOV 25	97.00	90.00		P
INFORMATION GOVERNANCE TRAINING	NOV 25	91.00	95.00	L	F
SAFEGUARDING CHILDREN L1	NOV 25	94.00	90.00		P
SICKNESS	NOV 25	7.15	4.50		F
TURNOVER	NOV 25	6.60	12.00	L	P
VACANCY	NOV 25	4.22	5.00	L	?

Alert

Information Governance remains behind the required 95%, slightly improving to 91% (90% in October). Executive push to improve compliance.
Non medical appraisal remains at 79%, behind the 90% Trust target. Rapid improvement week being planned to improve appraisal compliance.
Sickness absence has increased again, to 7.15% (6.99% in October)

Advise

81% of Consultants have a job plan either live or in the sign off stage, up from 79% in October. 84% of non-Consultant grades have a live job plan or are awaiting signature (consistent with October).

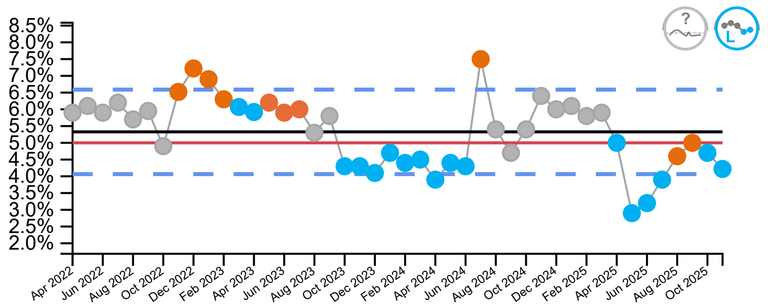
Assurance

Appraisal compliance for medics continues to be above target – 96% for Consultants (up from 95% in October) and 97% for other medics (up from 94%).
Vacancy levels and turnover remain within thresholds.

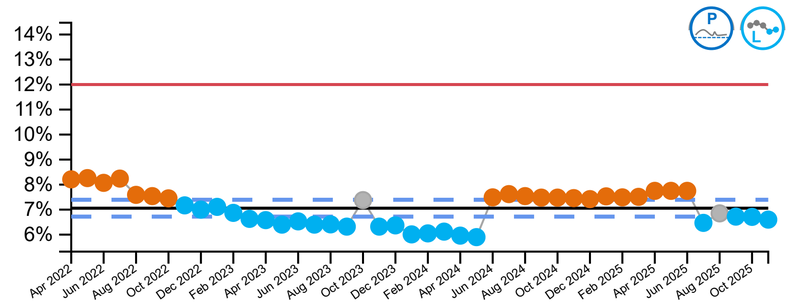
WELL LED - HR

East Lancashire Hospitals NHS Trust
A University Teaching Trust

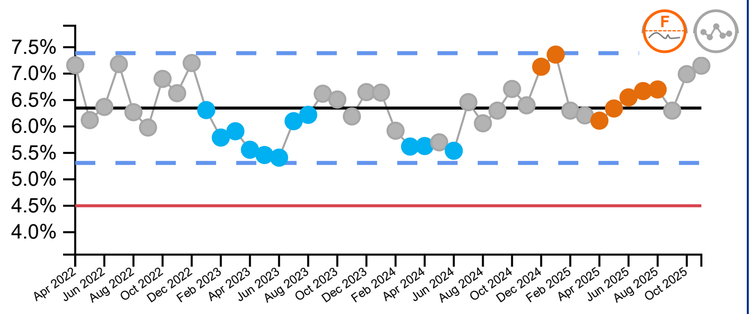
Vacancy



Turnover



Sickness



Freedom to Speak Up Cases by Elements

Concerns with elements of...

Reporting Period	Patient safety	Behaviour & attitudes	Bullying & harassment	Worker safety & wellbeing	Overall number of cases
24/25 Q1	3	21	11	18	40
24/25 Q2	0	35	16	34	61
24/25 Q3	4	29	7	22	115
24/25 Q4	2	32	12	32	97
25/26 Q1	6	25	8	34	76
25/26 Q2	3	40	25	37	64

Job Plans

Stage	Consultants	Non consultants grades
Awaiting Signatures	139	28
Complete	108	52
Due Soon	10	3
In Progress	55	15
No Current Job Plan	8	2
Not Started	61	16
Referred Back	2	2
Uploaded	0	0
Total	**383**	**118**

WELL LED - Learning and Development

East Lancashire Hospitals NHS Trust
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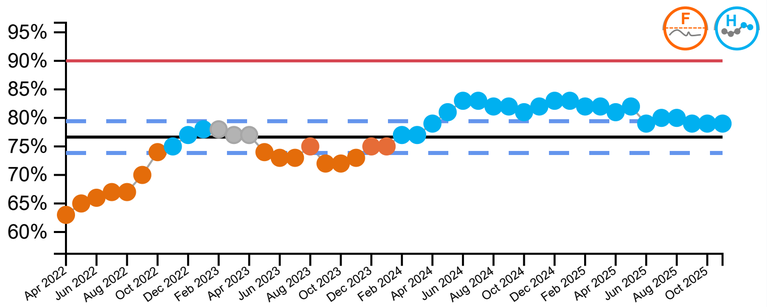
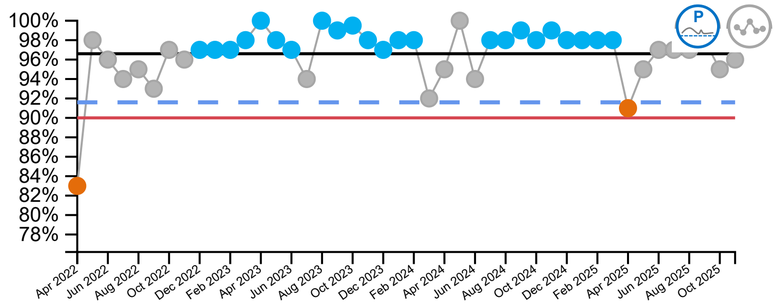
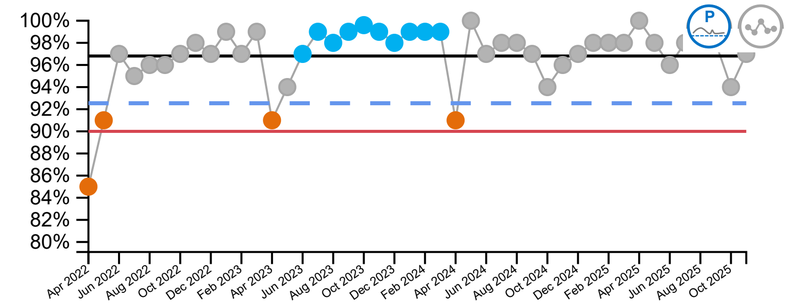
Appraisal (agenda for change)



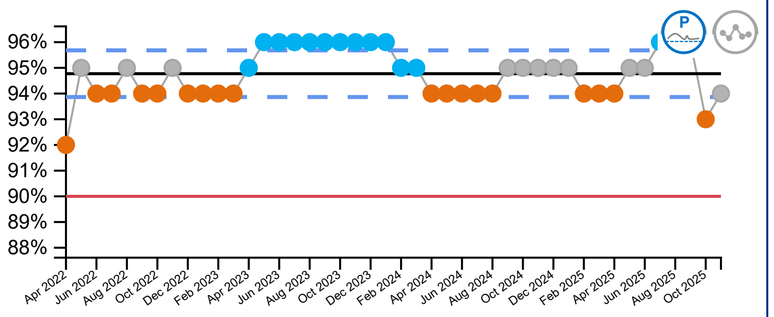
Appraisal (consultant)



Appriasal (other medical)

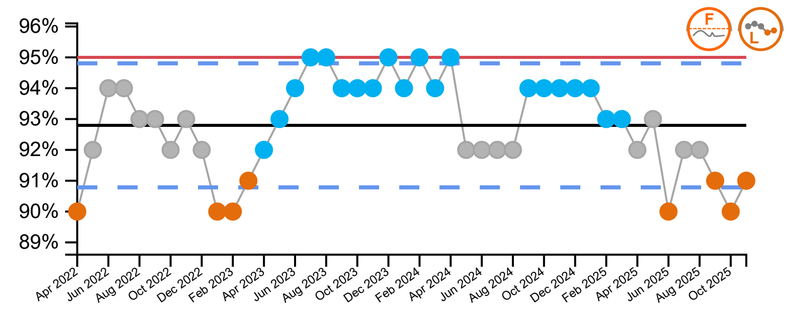


Safeguarding Children L1



Module	Target	Compliance
Basic Life Support	90.00	0.86
Conflict Resolution L1	90.00	0.96
Equality, Diversity and Human Rights	90.00	0.95
Health, Safety and Welfare	90.00	0.94
Infection Prevention L1	90.00	0.98
Infection Prevention L2	90.00	0.90
Prevent	90.00	0.95
Safeguarding Adults L1	90.00	0.92
Safeguarding Adults L2	90.00	0.94
Safeguarding Adults L3	90.00	0.84
Safeguarding Children L1	90.00	0.94
Safeguarding Children L2	90.00	0.94
Safeguarding Children L3	90.00	0.89
Safeguarding Children L4	90.00	1.00
Fire Safety	95.00	0.94
Freedom to Speak Up	95.00	0.85
Information governance training	95.00	0.91
Safer Handling L1	95.00	0.95
Safer Handling L2 (Patient Handling)	95.00	0.92

Information governance training



WELL LED FINANCE - Summary Scorecard

East Lancashire Hospitals NHS Trust
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METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION	ASSURANCE
BETTER PAYMENT PRACTICE CODE (BPPC) NHS NO OF INVOICES	NOV 25	79.90	95.00	L	?
BETTER PAYMENT PRACTICE CODE (BPPC) NHS VALUE OF INVOICES	NOV 25	67.10	95.00	L	?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS NO OF INVOICES	NOV 25	58.24	95.00	L	?
BETTER PAYMENT PRACTICE CODE (BPPC) NON NHS VALUE OF INVOICES	NOV 25	92.82	95.00		?
LIQUIDITY DAYS	NOV 25	-31.44	-21.50	L	?
VARIANCE TO PLANNED FINANCIAL PERFORMANCE (DEFICIT) (£M)	NOV 25	-3.17	0.00		?
WRP ACHIEVED - VARIANCE TO PLAN (£M)	NOV 25	-1.91	0.00		?
AGENCY SPEND AS PROPORTION PAY BILL (£M)	NOV 25	0.64	1.20	L	P
VARIANCE TO CAPITAL PROGRAMME (£M)	NOV 25	0.89	0.00		?

METRIC	LATEST DATE	VALUE	ALT. TARGET	VARIATION
EMPLOYEE EXPENSES RUN RATE (£M)	NOV 25	48.33		H
INCOME RUN RATE (£M)	NOV 25	68.95		H
OTHER OPERATING EXPENSES RUN RATE (£M)	NOV 25	21.57		H

Alert

Cash Risk and DSF Conditions: The Trust faces a critical cash risk associated with DSF being withheld due to under performance against the financial plan. Immediate focus on cost reduction and delivery of WRP is needed to maintain our cash balance. The Trust have made a cash application approved by the board.
WRP Delivery: The Trust achieved £3.5m WRP in Month 8 against a reprofiled plan of £6.5m. Cumulatively the Trust had delivered £25.5m of savings which is £9m adverse to the reprofiled plan. The risk adjusted forecast is £61.3m (excluding DSF).
Workforce Spend: Pay spend decreased in M08 v M07 by £0.5m.
Contracting and Activity Planning: Activity and finances have been agreed for 2025-26 contract and the contract has been signed. Contract does not reflect activity being delivered through the NEL pathways or in Maternity. Deconstruction of the block contract guidance has been issued for 2026-27. Formal contract meetings have commenced for 2025-26.

Advise

WRP Reporting Alignment: There is good progress to streamline and align reporting between PMO, finance, and improvement teams at Divisional and Trust level. An in-house team has been developed with fully automated reporting for WRP using Power Bi.
Cash Flow Management: The monthly cash flow forecast is based on the risk adjusted revenue position. The cash balance decreased by £0.9m to £15m in November, the cash position is being monitored closely with significant risks remaining.
System Collaboration: Continued engagement with ICB and system partners is essential, particularly around shared savings schemes and commissioning intentions.

Assurance

The Trust has agreed a break-even annual financial plan for 2025-26, inclusive of £43.3m Deficit Support Funding (DSF). To deliver this plan, the Trust has a Waste Reduction Programme (WRP) of £60.8m.
The Trust is reporting a deficit of £5.9m for M8, £3.2m behind the planned position. This is the deficit excluding £3.6m of DSF.
The year-to-date position, excluding £25.3m of DSF, is a £46.9m deficit, £13.4m behind the planned position of £33.5m.
The WRP delivered £3.5m in month, a variance of £2.5m to the original plan of £6.0m. Year to date, the WRP delivered is £25.5m against the original plan of £36.3m, a variance of £10.8m. This reflects the phasing of the £15.4m unidentified at the time of submission to NHSE, which is in equal 12ths in line with NHSE guidance. Plans have been made to mitigate this under performance in the latter end of the year.
Cash - The cash balance at the end of November was £15m, a decrease of £0.9m compared to £15.9m at the end of October.
Capital - The 2025-26 capital plan is £44.2m. While the year to date spend at M8 of £15.4m is £2.5m ahead of plan, the Trust is still forecasting not to exceed the annual plan.

WELL LED - Finance

East Lancashire Hospitals NHS Trust
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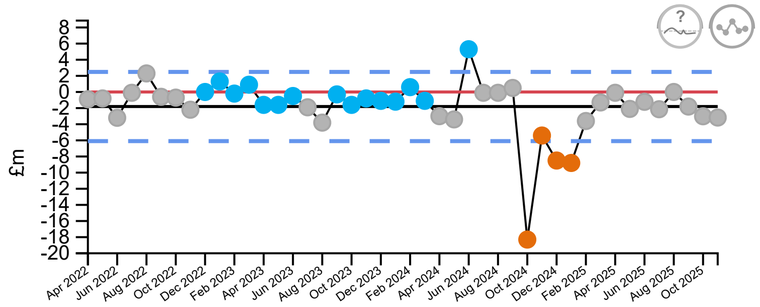
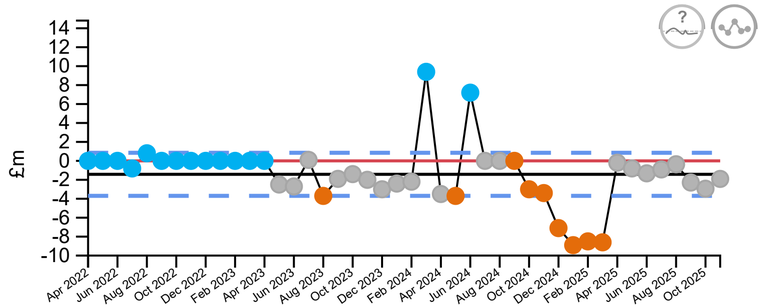
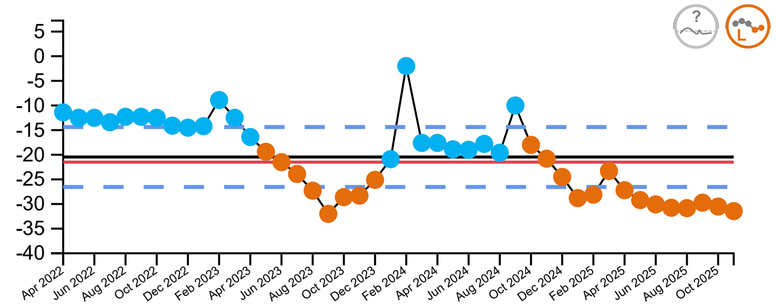
Variance to planned financial performance (deficit) (£m)



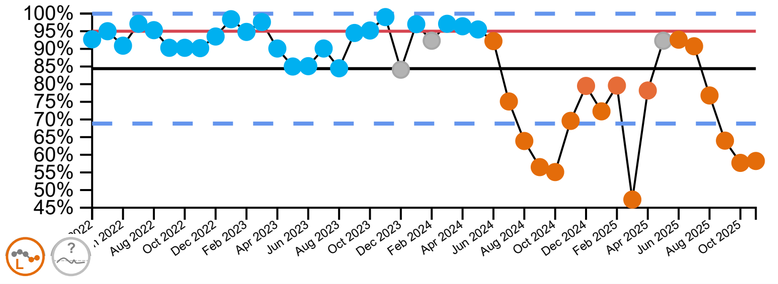
WRP achieved - variance to plan (£m)



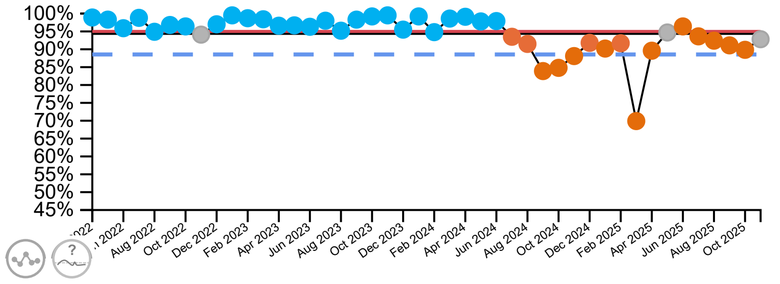
Liquidity days



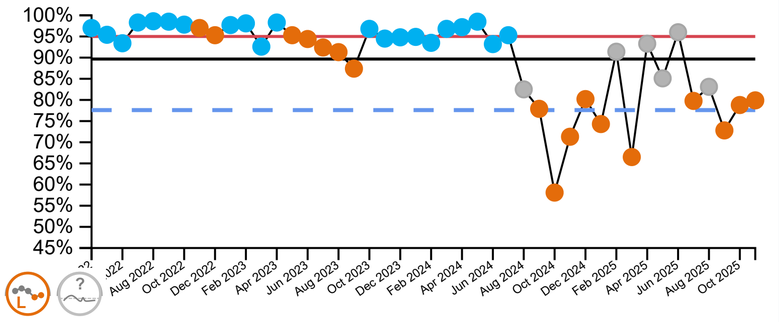
Better Payment Practice Code (BPPC) Non NHS No of Invoices



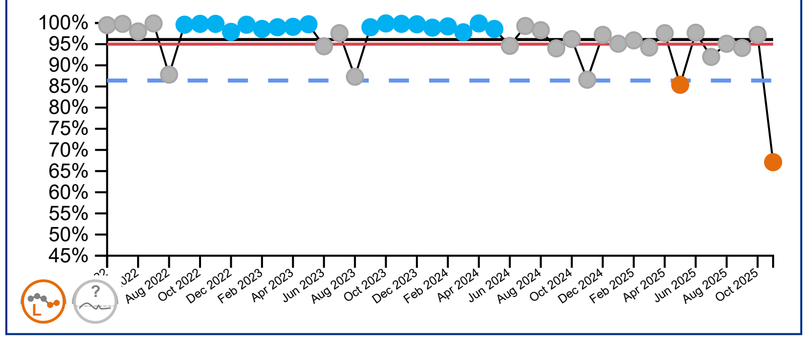
Better Payment Practice Code (BPPC) Non NHS Value of Invoices



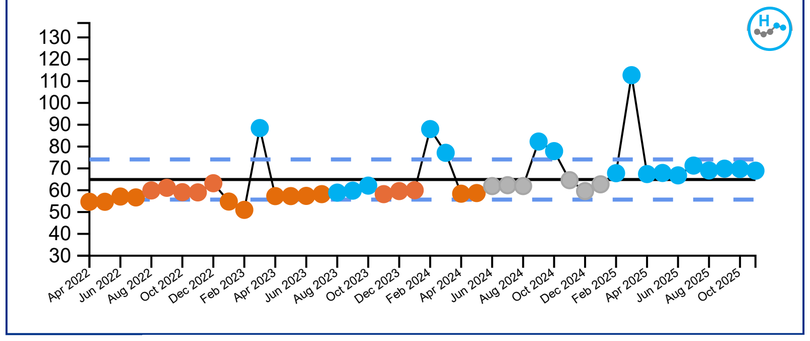
Better Payment Practice Code (BPPC) NHS No of Invoices



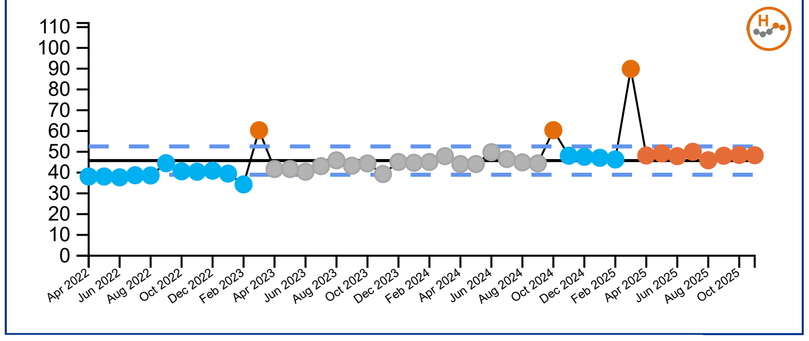
Better Payment Practice Code (BPPC) NHS Value of Invoices



Income run rate (£m)



Employee expenses run rate (£m)



Safe | Personal | Effective

Employer contributions to NHS pensions paid by NHS E on behalf of the trust are removed from March figures.

WELL LED - Finance

East Lancashire Hospitals NHS Trust
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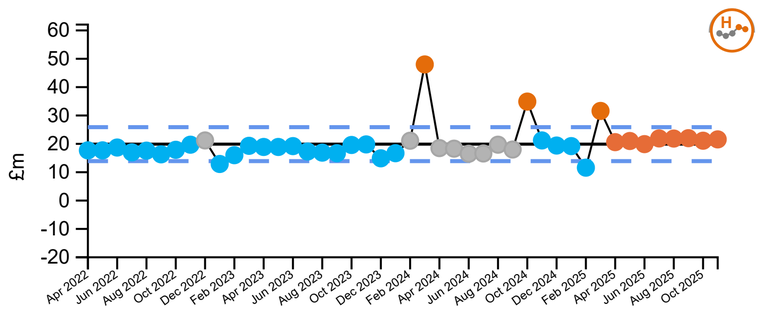
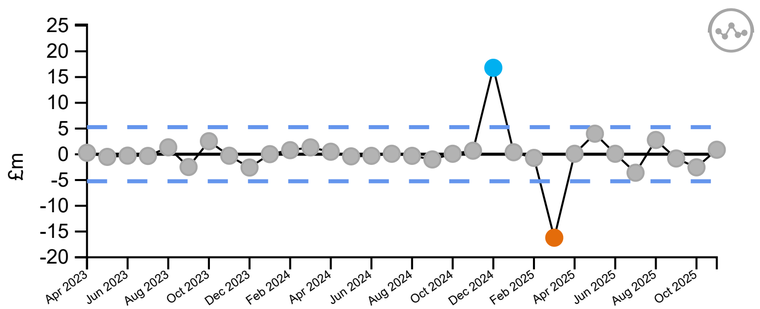
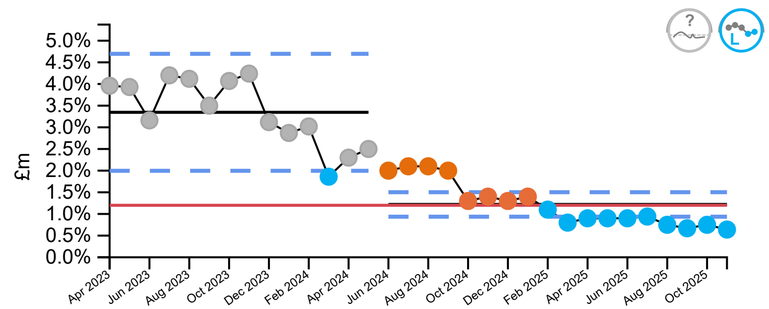
Other operating expenses run rate (£m)



Variance to capital programme (£m)



Agency spend as proportion pay bill (£m)



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TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/011
Report Title:	East Lancashire Hospitals NHS Trust Improvement Plan (RSP Exit Criteria)		
Author:	Catherine Vozzolo, Associate Director of Service Development		
Lead Director:	Kate Atkinson, Director of Service Development & Improvement		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan has been developed to support the Trust to evidence the improvement actions underway and associated impact in response to meeting the Recovery Support Programme (RSP) Exit Criteria and associated Legal Regulatory Undertakings. The Improvement plan was first presented to Trust Board in July 2025 in draft format and following feedback from Board members and NHSE improvement leads has now been updated to its current form. For months 4 and 5 the Improvement Plan has been reported internally. From month 6 (November 2025) it has been reported through to the Trust Board, the ELHT Improvement and Assurance Group (IAG) with the ICB and then to NHSE for review and sign off. The Improvement Plan is supported by a detailed delivery plan to ensure completion of all exit criteria. It is monitored through the Finance Improvement Group (FIG), which will ensure clear oversight of the plan's delivery. The FIG reports to the Trust Board and the Improvement and Assurance Group (IAG). The Improvement Plan is also monitored at Trust Board subcommittees (People & Culture Committee, Finance & Performance Committee and Audit Committee). Progress has been made in compiling relevant evidence and cross reference in all aspects of the improvement plan. The key messages at Month 8 are: • At Month 8 the year to date financial position is a deficit of £46.9m against a deficit plan of £33.5m therefore £13.4m behind plan (excluding the DSF). YTD delivery of the Waste			

	Reduction Programme continues to improve to £25.5m but this is £9m behind our re-profiled plan. • Work is ongoing to improve this through identification of mitigations and to continue to deliver the agreed financial plan. • Updates are made to Criteria 2 to reflect ongoing progress with implementation of the Grip and Control recommendations and the Trust is working positively with PwC to evidence implementation and identify any new areas of opportunity to further strengthen and evidence delivery. • New updates are made to Criteria 3 (Develop a medium-term financial recovery plan) to reflect the 1st draft medium-term planning submission made in December 2025. There is significant work required to ensure the development of the final plan and the Trust is committed to working as a system partner to ensure the final plans are deliverable and credible. The completion dates for Criteria 3 is proposed to be changed to reflect the national planning timetable to 31st March. • Progress on Criteria 5 is noted in particular with the establishment of the Programme Management Office function and new Programme Director leadership arrangements for the financial recovery programme. Going forwards it has been agreed that the Trust will develop a Single Improvement Plan to include other key improvement actions (as required) in addition to the RSP Exit Criteria. Initial scoping of this has begun and this will be presented to future Improvement and Assurance Groups. Work will also commence on the development of a presentation to March IAG against all Exit Criteria, the Trust's forward strategy and next steps upon transition from the Recovery Support Programme.
Key Issues/Areas of Concern:	The key risk is the current performance of the financial plan at Month 8 being behind plan by £13.4m (excluding DSF). Work is ongoing to improve this through identification of mitigations and to continue to deliver the agreed financial plan.
Action Required by the Committee:	Members are asked • to note the updated improvement plan and provide further comments or feedback on the content of the plan. • to confirm whether the self-assessment is accurate and therefore approved, or whether further recommendations can be made.

Previously Considered by:	Executive Team Meeting
Date:	6th January 2026

Outcome:	Improvement Plan feedback noted and is now included in the report to Trust Board.

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East Lancashire Hospitals NHS Trust Improvement Plan

Update Report Month 8

Improvement Plan Contents

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Introduction to the Improvement Plan

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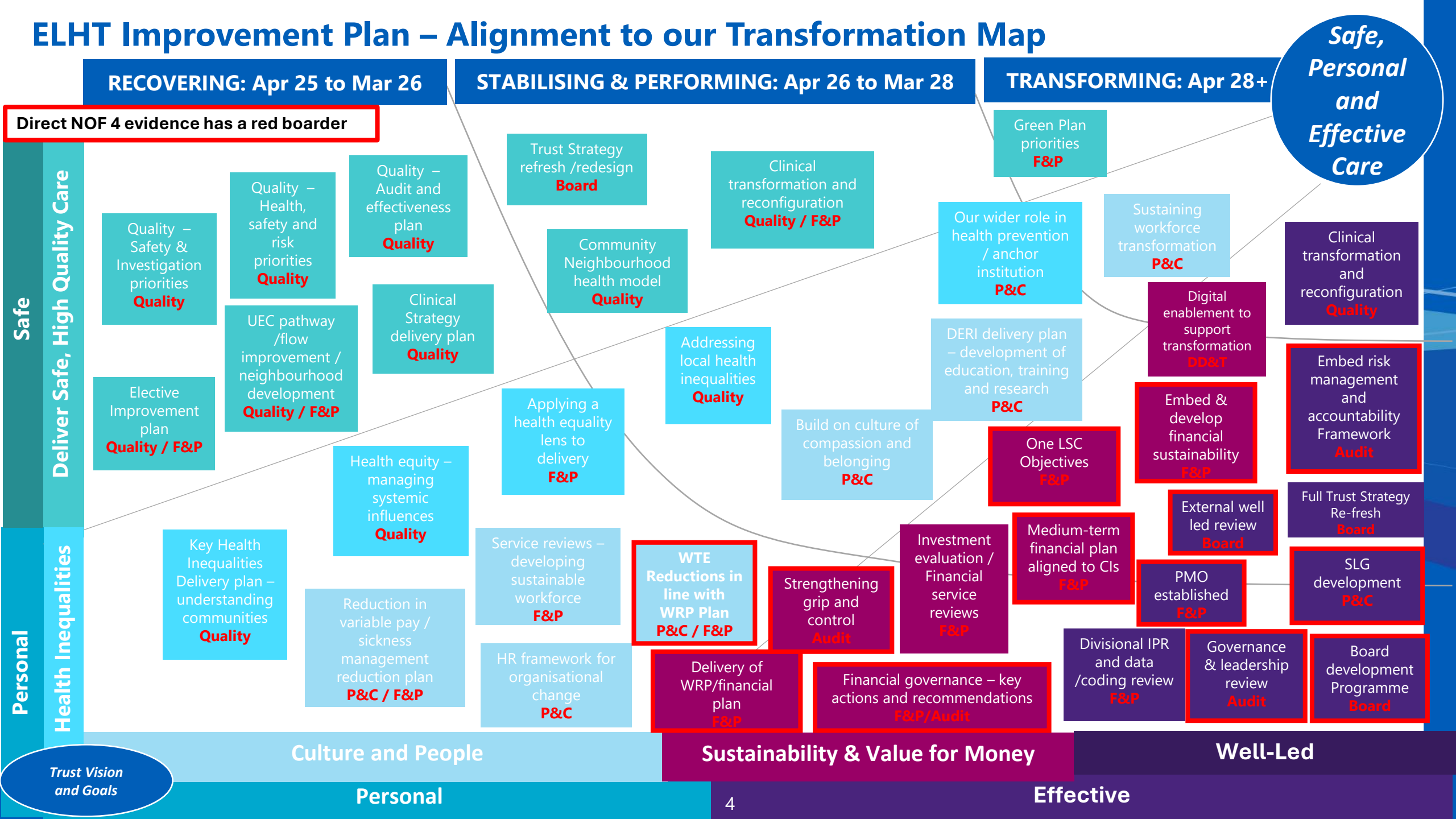
- The East Lancashire Hospitals NHS Trust (ELHT) Improvement Plan has been developed to support the Trust to evidence the improvement actions underway and associated impact in response to meeting the Recovery Support Programme (RSP) Exit Criteria and associated Legal Regulatory Undertakings.

- The Improvement Plan is rooted in our operational performance and outcomes, recognising the contributions our colleagues make every day, whilst acknowledging the impact of a deteriorating financial outlook and the requirement to strengthen our leadership and governance, which must now be improved. This is what Safe, Personal and Effective care means for ELHT.

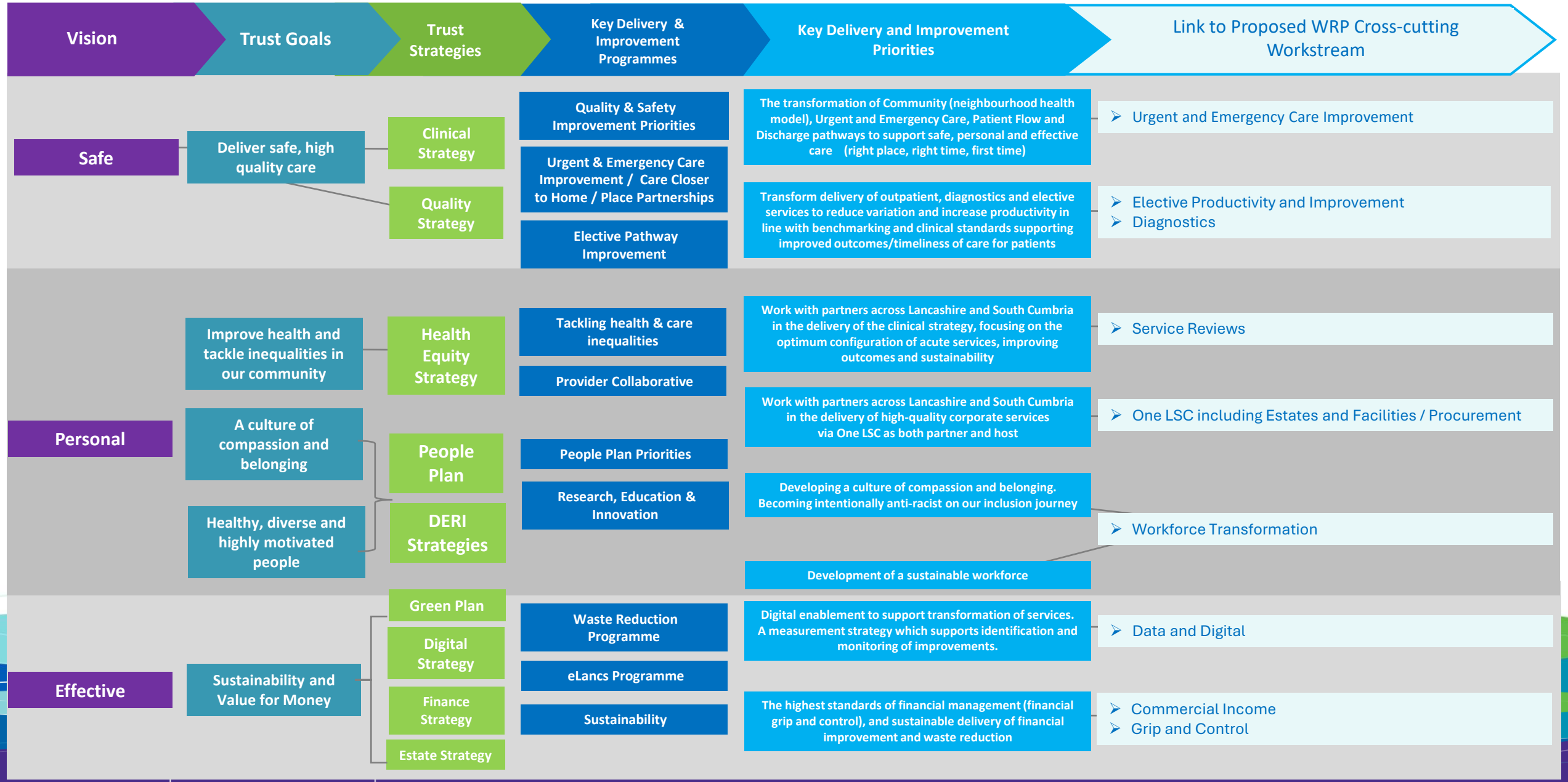
- It is vital that the Improvement Plan does not become a means by which to oversee all Trust operations and is focussed on the key RSP Exit Criteria. However, there is a clear link between these improvement actions and the daily running of the Trust and delivery of its wider ambitions and improvement plans which is shown on our Transformation Map; an outline of the supporting governance by which the actions in the plan will be scrutinised is set on out page 7.

- **Going forwards it has been agreed that the Trust will develop a Single Improvement Plan to include other key improvement actions (as required) in addition to the RSP Exit Criteria. Initial scoping of this has begun and this will be presented to future Improvement and Assurance Groups.**

ELHT Improvement Plan – Alignment to our Transformation Map



ELHT Strategic Framework - WRP cross-cutting workstreams and alignment



Multi-Year Recovery Plan

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One-year plans and priorities have been agreed for 2025026. Over 2025-26 the Trust Strategy will be refreshed (and all associated strategies/plans) to support greater alignment to the wider system and reflective of a multi-year recovery plan.

AIM	Recovering	Stabilising	Performing	Transforming
	Urgent recovery and steadying the ship…		**Getting into the pack and leading the field**	
	2025/26 – 2026/27		2027/28 – 2028/29 & beyond..	
OBJECTIVES	• NOF 4 Improvement plan and Transformation Map is defined and mobilised • Review and re-fresh of Trust Strategy to align to Trust and System Improvement Plan		• Improvement plan is delivered, long-term vision designed and delivering • Improvement Plan is delivered to ensure ongoing delivery of Safe, Personal and Effective Care • System leader, collaborating for Lancashire and South Cumbria to thrive	
OUTCOMES	• **Improvement plan defined and resourced** • **Programme Management Office mobilised and aligned to SPE+ Improvement Practice**	• **Improvement plan and programmes delivering to plan** • **Evidence and confidence that Legal Undertakings / Exit Criteria are met** • **Exit from NOF4 of Recovery Support Programme**	• **Outstanding provision of care and financially stable** • **Place of choice to work, train and thrive** • **Upper quartile performance nationally**	

Full alignment to NOF4 Exit Criteria required alongside key system strategies/plans

Improvement Plan Governance and Reporting

East Lancashire Hospitals NHS Trust
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Supporting Delivery – Our Programme Management Office, SPE+ Improvement Practice and Communications Approach

The Improvement Hub Team:

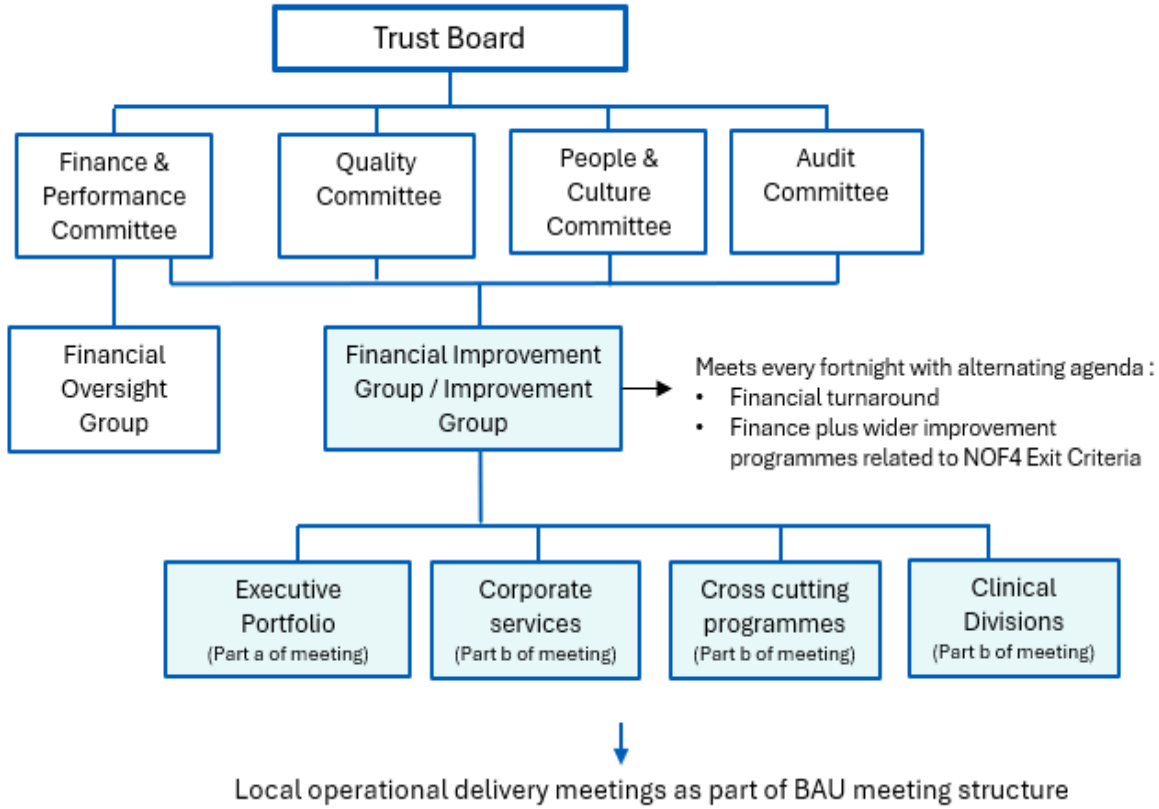
- Develop 'Daily Management' principles based on continuous improvement
- Continue to build Improvement capability and capacity
- Create a wider network of sharing good practice through ELHT and wider system partners
- Support measurement of all work to strengthen a data-based approach
- Support wider improvement beyond financial recovery to support delivery of our vision for Safe, Personal and Effective Care

The PMO:

- Provide a systematic approach to support delivery of financial recovery
- Develop standardisation of project management practices
- Provide governance of processes strengthening assurance
- Support risk management of overall delivery

Our communication and engagement plan will:

- Support our colleagues in understanding the challenge, put forward their ideas and celebrate success



Cross-Cutting Workstreams

9 Cross-cutting workstreams have been identified and aligned to the Trust's framework of Key Delivery and Improvement Programmes and Priorities for 2025/26.

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Trust Strategy	Key Delivery & Improvement Programmes 25/26	Cross Cutting Workstream	Task and Finish Groups	Executive Sponsor	Assurance Committee
People Plan	People Plan Priorities	Workforce Transformation	MARS, E-Rostering, Job Planning, Sickness & Absence, Bank/ Agency/Volume, Spans & Layers	Chief People Officer	People & Culture
Clinical & Quality Strategy	Elective Pathway Improvement	Elective Productivity Improvement	Theatres, Outpatients, Elective Flow.	Chief Operating Officer / Director of Service Development & Improvement	Finance & Performance
		Diagnostics	Pathology, Meds Management, Pharmacy*, Diagnostic Imaging	Medical Director	Quality
	Urgent & Emergency Care Improvement	UEC Improvement Plan	UEC/ NEL incl. Los.	Chief Nurse / Chief Integration Officer	Quality
Health Equity Strategy	Tackling Health & Care Inequalities	Service Reviews	Specialty / CI Reviews, Service Reviews, Post Investment Reviews	Director of Service Development & Improvement	People & Culture
Finance Strategy	Sustainability	Commercial Income	Non-NHS, Philanthropy, R&D, Coding.	Director of Communications	People & Culture
		OneLSC	Procurement*, Contracts, SLAs, PFI, E&F.	Director of Finance / Chief Integration Officer	Finance & Performance
		Grip & Control	Pay/ Non-Pay Panels, Investigations.	Director of Finance	Finance & Performance
Digital Strategy	WRP	Data & Digital	Data & Digital, Cerna AI, OneLSC Digital.	Chief Integration Officer	Data, Digital & Technology

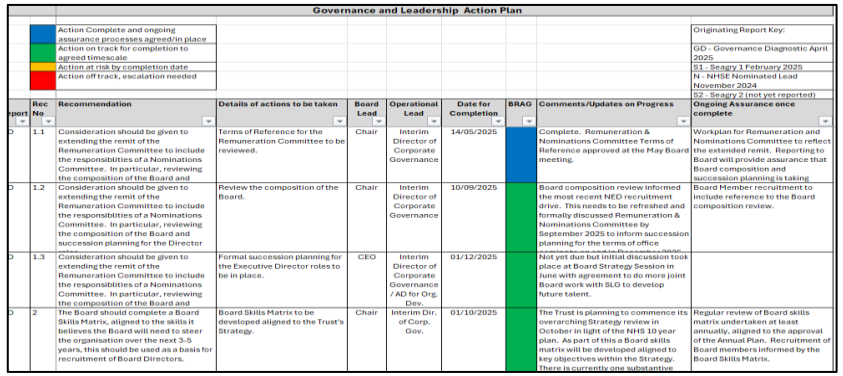
Leadership and Governance Reviews

East Lancashire Hospitals NHS Trust
A University Teaching Trust

The Governance & Leadership Action plan incorporates the recommendations from 4 reviews. The action plan was approved by Trust Board in July and endorsed through IAG on 29th July 2025. It is monitored via the Audit Committee. There are 88 actions in total, as of December 2025 68 have been completed. The completion of actions will be tested during Quarter 4 by Internal Audit.

L&G Review	Key Actions Required
NHSE Nominated Lead Report (November 2024)	The final report identified 16 recommendations for action. All complete.
Financial Governance Review (initial review)	The Finance Governance Review was commissioned and undertaken by Seagry Consultancy Ltd. The final report identified 13 recommendations for action. All complete.
Governance Diagnostic Report	The report provides an assessment of the corporate governance arrangements within the Trust. The report includes 18 recommendations to address the identified areas for improvement. 18 actions are complete, 7 actions on track and 1 action is behind deadline.
Financial Governance Review (wider review)	Phase 2 Financial Governance Review commissioned and undertaken by Seagry Consultancy. The report includes 26 recommendations. All the recommendations have been incorporated into the Governance and Leadership Action Plan. 14 actions are complete, 11 actions on track and 1 action is behind deadline.

Governance & Leadership Action Plan :



Governance and Leadership Action Plan

Rec No	Recommendation	Details of actions to be taken	Board Lead	Operational Lead	Date for Completion	BRAG	Comments/Updates on Progress	Ongoing Assurance once complete
1.1	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and	Terms of Reference for the Remuneration Committee to be reviewed.	Chair	Interim Director of Corporate Governance	14/05/2025		Complete. Remuneration & Nominations Committee Terms of Reference approved at the May Board meeting.	Workplan for Remuneration and Nominations Committee to reflect the extended remit. Reporting to Board will provide assurance that Board composition and succession planning is taking
1.2	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and succession planning for the Director	Review the composition of the Board.	Chair	Interim Director of Corporate Governance	10/09/2025		Board composition review informed the most recent NED recruitment drive. This needs to be refreshed and formally discussed Remuneration & Nominations Committee by September 2025 to inform succession planning for the terms of office	Board Member recruitment to include reference to the Board composition review.
1.3	Consideration should be given to extending the remit of the Remuneration Committee to include the responsibilities of a Nominations Committee. In particular, reviewing the composition of the Board and	Formal succession planning for the Executive Director roles to be in place.	CEO	Interim Director of Corporate Governance / AD for Org. Dev	01/12/2025		Not yet due but initial discussion took place at Board Strategy Session in June with agreement to do more joint Board work with SLG to develop future talent.	
2	The Board should complete a Board Skills Matrix, aligned to the skills it believes the Board will need to steer the organisation over the next 3-5 years, this should be used as a basis for recruitment of Board Directors.	Board Skills Matrix to be developed aligned to the Trust's Strategy.	Chair	Interim Dir. of Corp. Gov.	01/10/2025		The Trust is planning to commence its overarching Strategy review in October in light of the NHS 10 year plan. As part of this a Board skills matrix will be developed aligned to key objectives within the Strategy. There is currently one substantive	Regular review of Board skills matrix undertaken at least annually, aligned to the approval of the Annual Plan. Recruitment of Board members informed by the Board Skills Matrix.

Originating Report Key:
GD - Governance Diagnostic April 2025
S1 - Seagry 1 February 2025
N - NHSE Nominated Lead November 2024
S2 - Seagry 2 (not yet reported)

Progress against the action plan is monitored operationally on a monthly basis by the Trust Improvement Group with assurance of delivery reported to the Audit Committee and Trust Board.

RSP NOF 4 Exit Criteria and Evidence Required

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1	2	3	4	5
Delivery of financial plan and Waste Reduction Programme	Deliver quarter-on-quarter run rate improvement throughout 2025/26	Develop a medium-term financial recovery plan covering the period post 2025/26	Demonstrate effective financial and organisational governance structures and mechanisms	Full participation in the Recovery Support Programme
2025/26 break-even position and deficit no more than the £43.3m planned	Quarter-on-quarter improvement in underlying run rate throughout 2025/26	A Board and IAG approved plan for financial recovery and maintenance beyond 2025/6 by the end of Q3	Development of an improvement plan to ensure timely response, evidence and completion of recommendations in the Governance Review of April 2025	Executive Board attendance at monthly IAG meetings
Achievement of £60.8m WRP and plans in excess of £61m to offset any under delivery	Robust expenditure controls in line with PwC recommendations		A Board/Improvement & Assurance Group agreed governance and leadership action plan in response to the recommendations for the Governance Review of April 2025,and following publication of the Seagry review outcomes	Engagement with Turnaround Director and team and response to requested actions
Delivery against key expenditure categories as outlined in the financial plan and WRP			Evidence of full board engagement in an externally commissioned (Value Circle) Board development programme which addresses the recommendations of the leadership review undertaken by the interim Director of Governance, fostering unitary behaviours	Timely and accurate reporting of finance data
A reduction in who time equivalent (WTE) staffing as agreed in the WRP			Identification of finance and org risks and effective controls in BAF, Risk Management Processes, AAA reports at Board and subcommittee level	Establishment of a Programme Management Office (PMO) and appointment of Senior Responsible Officers (SRO) to manage delivery of financial and organisational plans
Finalisation of Commissioning Intentions with the ICB along with associated costs and in-year and medium-term impact assessment			Management of executive vacancies in line with ICB change programme mandates and through notification to and involvement with the NHSE regional team	
			Demonstrable assurance that any risk to quality and patient safety through WRP is mitigated	

Regulatory Undertakings - ELHT

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Undertaking Focus	Key Actions
Financial Planning	1.1 Within a timeframe set by NHS England, the Licensee will agree a 2025/26 Financial Plan with NHS England.
	1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 4 2024/25 and throughout 2025/26.
	1.3 The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the IAG.
Recovery Support Programme	2.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Exit Criteria as set out and agreed by the IAG, in accordance with the timescales agreed by the IAG.
	2.2 The Licensee will carry out a review of progress against the RSP Exit Criteria and report to the IAG, in accordance with the timescales agreed by the IAG.
	2.3 In line with the IAG Terms of Reference and the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address the concerns which these undertakings seek to address.
Leadership and Governance	3.1 The Licensee will co-operate and engage as required with the "Governance and Leadership Review" initiated by NHS England and led by an NHS England appointed Improvement Director.
	3.2 The Licensee will ensure that it has in place sufficient and effective Board and management leadership capacity and capability, as well appropriate governance systems and processes to enable it to: 3.2.1 comply with the undertakings at paragraphs 1 and 2 effectively; and 3.2.2 address any other issues relating to governance or operations that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breach of the conditions of the Licensee's licence
	3.3 The Licensee will inform NHS England prior to recruitment to executive board level posts and will (a) share the relevant person specifications with NHS England in draft for NHS England's comment. (b) provide a timetable for the appointment, and (c) ensure that there is NHS England representation on the interview panel.
Meetings and Reports	5.1 The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above.
	5.2 The Licensee will attend monthly IAG meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. IAG meetings will be led by the System Financial Turnaround Director, with attendees specified by NHS England.
	5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.
	5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.
Funding Conditions and Spending Approvals	4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee under Schedule 5 to the National Health Service Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.
	4.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to schedule 5 to the NHS Act 2006.
	4.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Improvement Plan Delivery Update

November 2025 Month 8 Report

Key messages this month

East Lancashire Hospitals NHS Trust
A University Teaching Trust

- At Month 8 the year to date financial position is a deficit of £46.9m against a deficit plan of £33.5m therefore £13.4m behind plan (excluding the DSF). YTD delivery of the Waste Reduction Programme continues to improve to £25.5m but this is £9m behind our re-profiled plan.
- Work is ongoing to improve this through identification of mitigations and to continue to deliver the agreed financial plan.
- On the basis of work still ongoing to identify all mitigations the RAG rating of all actions relating to delivery of the financial plan for Criteria 1 remain unchanged from last month. It is proposed that the 2 actions in relation to commissioning intentions need their completion dates updating to end January 2025 need to reflect the revised timetable for medium-term planning.
- Updates are made to Criteria 2 to reflect ongoing progress with implementation of the Grip and Control recommendations and the Trust is working positively with PwC to evidence implementation and identify any new areas of opportunity to further strengthen and evidence delivery.
- New updates are made to Criteria 3 (Develop a medium-term financial recovery plan) to reflect the 1st draft medium-term planning submission made in December 2025. There is significant work required to ensure the development of the final plan and the Trust is committed to working as a system partner to ensure the final plans are deliverable and credible. The completion dates for Criteria 3 is proposed to be changed to reflect the national planning timetable to 31st March.
- Progress on Criteria 5 is noted in particular with the establishment of the Programme Management Office function and new Programme Director leadership arrangements for the financial recovery programme.
- Going forwards it has been agreed that the Trust will develop a Single Improvement Plan to include other key improvement actions (as required) in addition to the RSP Exit Criteria. Initial scoping of this has begun and this will be presented to future Improvement and Assurance Groups.
- Work will also commence on the development of a presentation to March IAG against all Exit Criteria, the Trust's forward strategy and next steps upon transition from the Recovery Support Programme.

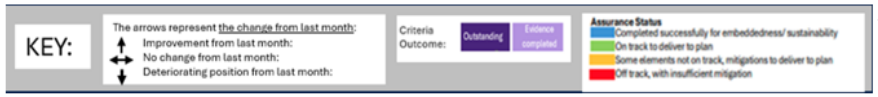
Month 8 Key Headlines

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Summary of Financial Position

- In month **deficit of £5.92m**, against **deficit plan of £2.76m** therefore **£3.16m behind the plan**.
- YTD **deficit of £46.9m** against; deficit plan of £33.5m therefore **£13.4m behind plan** (excluding the DSF).
- In month **WRP delivered £3.5m** against the WRP Delivery plan, therefore **£3m adverse to plan** (£2.5m adverse to PFR plan) (£4.1m reported to correct the YTD WRP value)
- YTD **WRP delivered £25.5m** against the WRP Delivery plan, therefore **£9m behind plan**. (£10.8m adverse to PFR YTD plan)
- **Cash balance** at the end of November was **£15m**, a reduction of £0.9m compared to M7 cash position of £15.9m.
- **Capital** plan 2025-26 is £42.0m. At M8, spend is **£15.4m**, £2.5m ahead of plan.
- Paid/worked WTE have increased by 81 WTE from Month 7 to **9,682**

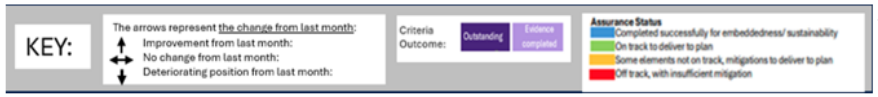
RSP NOF 4 Exit Criteria- Summary November 2025



Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria	Delivery	Risk	Update/Escalations at Month 8	Assurance gap reason	Overall Outcome
1. Deliver the financial plan submitted as agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025.	↓	↓	Trust Board has approved a financial plan for 2025/26. The WRP plan is in place with an initial plan of £60.8m at fully developed but as at M8 there continues to be slippage against delivery of the plan. Initial mitigations have been developed and work is ongoing to develop further opportunities before year end. The Workforce plan was agreed with a plan of 650 WTE reduction in year. Work is now ongoing to revise the workforce plan to ensure it mirrors delivery year to date and the proposed mitigations. A grip and control action plan is in place with monitoring through the Audit Committee. Work is ongoing to enhance grip and control measures and to bring actions forward to maximise benefit for 2026/27. The Financial Improvement Group is now in place to oversee delivery of the financial recovery plan and this continues to mature. M8 saw an in month deficit of £5.92m, against deficit plan of £2.76m therefore £3.16m behind the plan. YTD deficit of £46.9m against; deficit plan of £33.5m therefore £13.4m behind plan (excluding the DSF). Month 8 WRP delivered £4.1m against the WRP Delivery plan, therefore £3m adverse to plan (£2.5m adverse to PFR plan) YTD WRP delivered £25.5m against the WRP Delivery plan, therefore £9m behind plan. (£10.8m adverse to PFR YTD plan)	Mitigation plans are not finalised (to be completed for M10)	Outstanding
2. Deliver quarter-on-quarter run rate improvement throughout 2025/26.	↔	↔	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.8m in Q1, a £1.4m improvement, and a further improvement of £0.6m to £21.2m at Q2. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 2026/27.	Evidence of delivery incomplete / not yet due (M12 actual position to determine final assessment)	Outstanding
3. Develop a medium-term financial recovery plan covering the period post 2025/26.	↓	↓	The L&SC system is working together to support the medium-term planning process. 1st draft submissions were made on 16th December 2025. The 1st draft submissions reflected the planning ask for performance/activity including RTT and non-elective demand and in reflecting this in the financial submission it is recognised this creates an affordability issue for the ICB. Work is ongoing to ensure that demand management, commissioning intentions, provider productivity and provider demand management are developed to include in 2nd submission plans. Further work is required to develop the workforce plan and to develop detailed delivery plans for the waste reduction programme linked to key transformation opportunities at provider and system level. The Trust is committed to developing a financial plan to meet the control total set by NHSE and to return to financial balance within 3 years, however this will require further discussion with commissioners about contracted values for activity and growth. Board assurance statements have been scored to reflect the further work to be completed. The Trust has commissioned additional support via the Recovery Support Programme to assist in the development of its medium-term financial plan and this will commence in January 2026.	Evidence of delivery is incomplete / not yet due (to be completed for M12 in line with national planning timescales)	Outstanding
4. Demonstrate effective financial and organisational governance structures and mechanisms.	↑	↑	Leadership and governance review completed and endorsed by RSP Improvement Director. Leadership and Governance Action Plan in place encompassing recommendations of independent financial governance reviews, NHSE nominated lead findings and governance review. A detailed Board development programme has been initiated, phase 1 is complete and phase 2 has commenced. The WRP process has been improved and monitoring process tightened. Progress against recommendations is evidenced in the action plan. In total there are 88 actions, 68 are complete, 18 are green and 2 are red- a full report is available at appendix 2. An internal audit review of the Trust's progress against the NHSE Legal Undertakings has commenced, which will include reviewing evidence for actions marked as complete.	Evidence of delivery is incomplete / not yet due (dates for outstanding actions scheduled for M10 and M11)	Outstanding
5. Full participation in the Recovery Support Programme	↑	↑	The Trust is fully engaged with the IAG, System Turnaround Director and national RSP leads in developing our programme. A financial recovery programme is in place, a PMO has been appointed and executive SROs identified for all programmes of work.	Evidence of delivery is incomplete / not yet due (final actions for PMO scheduled for M10)	Outstanding

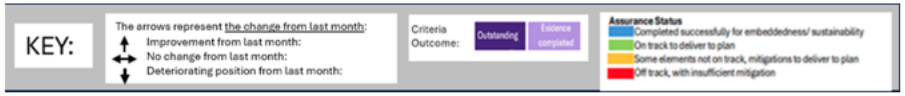
Regulatory Undertakings - Summary November 2025



Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Regulatory Undertakings	Delivery	Risk	Update/Escalations at Month 8	Assurance gap reason	Overall Outcome
Financial planning	↓	↓	The financial plan has been agreed with Trust Board and with NHS England All documented actions through IAG have been completed on a monthly basis. There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.8m in Q1, a £1.4m improvement, and a further improvement of £0.6m to £21.2m at Q2. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 2026/27. There is slippage in the WRP plan at M8YTD of £9m and work is underway to identify and implement mitigations.	Reporting shows adverse variance (M12 actual position to determine final assessment on delivery of financial plan)	Outstanding
Recovery Support Programme	↑	↔	A detailed improvement plan has been developed, including supporting delivery plan outlining key actions with Exec SRO accountabilities. Further work has taken place this month on delivery against the cross cutting workstreams by Exec SROs with their teams. The improvement plan will now be further developed to become a Single Improvement Plan and a presentation will be given to the March IAG on progress against all crtiera and next steps.	Evidence of delivery is incomplete / not yet due (presentation to be given at M12 IAG)	Outstanding
Leadership & governance	↔	↔	Our governance and leadership action plan combines recommendations from all reviews completed. Recommendations are well in progress with more completed this month. The Board development plan is in place with initial sessions completed.	Evidence of delivery is incomplete / not yet due (dates for outstanding actions scheduled for M10 and M11)	Outstanding
Funding conditions and spending approvals	↑	↑	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activites.	N/A - complete but evidence sign off required to show overall outcome as complete	Outstanding
Meetings and reports	↑	↑	Further work has been completed on the governance process underpinning to delivery of exit criteria and financial recovery including the establishment of the Financial Oversight Group and the Financial Improvement Group. Financial reporting to F&P Committee and oher groups has been significantly improved.	N/A - complete but evidence sign off required to show overall outcome as complete	Outstanding

Exit Criteria 1 – Progress Update

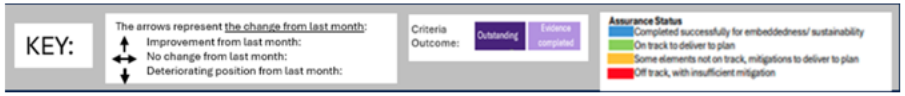


Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not get due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (1):	Reporting Mechanisms:	Recommended Outcome:
Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025.	- Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan. - Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.	**Outstanding / In progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
A 2025/26 financial outturn break-even position and overall financial deficit of no more than the £43.3m planned.							
	1. Financial plan for 25/26 agreed and signed off			01-Jun-25	Executive Director of Finance	Financial plan agreed in April 2025 and initial WRP plan agreed in June 2025.	N/A - Complete
	2. Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan.	↓	↓	31-Mar-26	Executive Director of Finance	A monthly financial report including income and outcome, run rate, deficit support position and staffing expenditure is now in place. This is reported actual and position against plan as required. This is reported through FOG (Finance Oversight Group) and to Finance & Performance Committee . It is also reported at IAG on a monthly basis. The summary financial report is also shared at our Senior Leadership Group with all senior leaders. M8: YTD deficit of £46.9m against; deficit plan of £33.5m therefore £13.4m behind plan (excluding the DSF). There has been a quarter-on-quarter run-rate reduction since Q3 24/25.	Reporting shows adverse variance (M12 actual position to determine final assessment on delivery of financial plan)
Achievement of the planned Waste Reduction Programme (WRP) £60.8m savings with fully developed Cost Improvement Plans (i.e. Board signed PIDs) in excess of £61m to offset any under delivery.							
	1a. Full WRP plan for 25/26 agreed			01-Jun-25	Chief Executive / Exec SROs	A full WRP plan for 25/26 is in place and was signed off in June 2025. All schemes are fully developed and delivery is being tracked through the PMO. QIRAs have been signed off by the Medical Director and Chief Nurse.	N/A - Complete
	1b. Delivery and Mitigation	↓	↓	31-Mar-26		The WRP schemes have been aligned with the cross cutting workstreams that have accountable officers. This is monitored operationally through Finance Improvement Group and Finance Oversight Group and through the Finance and Performance Committee. It is also reported through IAG on a monthly basis. Month 8 WRP delivered £4.1m against the WRP Delivery plan, therefore £3m adverse to plan (£2.5m adverse to PFR plan) YTD WRP delivered £25.5m against the WRP Delivery plan, therefore £9m behind plan. (£10.8m adverse to PFR YTD plan) Work is ongoing to ensure mitigations are identified and implemented to deliver the financial plan.	Mitigation plans are not finalised (to be completed for M10)
	2. F&P WRP progress update report	↑	↑	31-Dec-25	Executive Director of Finance	A detailed F&P progress report continues to be developed and refined to support appropriate reporting through FIG and the financial recovery report to F&P. The Financial Oversight Group also supports/tightens reporting governance through F&P. Work is ongoing to refine this based on implementation of a revised WRP tracker and development of new reporting capabilities.	N/A - Complete
	3. Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.	↑	↑	31-Mar-26	All Executive SROs	Monthly IAG reports completed to meet all specificed requirements.	N/A - Complete
Delivery against key expenditure categories as outlined in the financial plan and WRP							
	Monthly reporting	↓	↓	31-Mar-26	All Executive SROs	Monthly financial reports to FOG, FIG and F&P.	Mitigation plans are not finalised (to be completed for M10)

Exit Criteria 1 – Progress Update

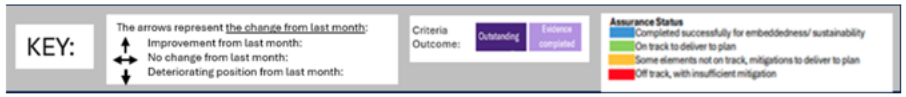


Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (1):	**Reporting Mechanisms:**	**Recommended Outcome:**
Deliver the financial plan submitted and agreed in April 2025 and the Waste Reduction Programme savings agreed in June 2025.	- Monthly financial reporting including income and outcome, and run rate, deficit support position and staffing expenditure. Reporting actual and position against plan. - Monthly IAG reports and meeting letters to identify CIP identification and delivery against plan and progress against key expenditure categories and service re-design changes.	**Outstanding / In progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
A reduction in whole time equivalent (WTE) staffing as agreed in the WRP.							
	1a. Detailed WTE staffing plan aligned to the WRP plan.			01-Jun-25	Chief People Officer	There is a detailed WTE plan aligned to our original WRP plan for 2526 which was developed in June 2025. A total of 650 WTE reduction is planned by month 12. A phased reduction plan is in place.	N/A - Complete
	1b. Delivery of WTE plan and Mitigations	↓	↓	31-Mar-26	Chief People Officer	The WTE plan is in the process of being fully reviewed in light of FOT analysis, the agreed mitigations and re-profiling will take place in accordance with mitigation plans agreed.	Mitigation plans are not finalised (to be completed for M10)
	2. Reduction in WTE as per the agreed profiled plan	↓	↔	31-Mar-26	Exec SROs	M8 WTE has increased by 66.65wte. This is driven by three main points: NQNs commencing, period of supernumery meaning double running 27wte correction from M7 around bank and Industrial action cover Whilst this remains behind plan the work is ongoing to re-profile the WTE plan in accordance with the mitigation plan.	Mitigation plans are not finalised (to be completed for M10)
Finalisation of commissioning intentions with the ICB along with associated costs and in-year and medium- term impact assessment.							
	Commissioning intentions summary including costs and in year/ medium term impact for 25/26 - relevant meeting letters and summarised reports	↓	↓	~~31/12/2025~~ Proposed new date to enable review of commissioner response when received: 31/01/26	Director of Service Development & Improvement	A plan for 2025-26 has been agreed. Finalisation of segment 0/1 commissioning intentions planned completed by end August 2025 but the final outcome needs finalising to feed into contracting discussions for 26/27. This needs urgently completing and was not completed ahead of 1st draft planning submissions in order to inform initial plans for 2026/27.	Mitigation plans are not finalised (to be completed for M10)
	Commissioning intentions for 2627 - summarised plan including income and cost assessment	↓	↓	~~31/12/2025~~ Proposed new date to enable review of commissioner response when received: 31/01/26	Director of Service Development & Improvement	Work ongoing with the ICB and Providers with PSC support on the development of commissioning intentions for 2026/27 with support from the PSC. The next phase is quantification of Commissioning Intentions for impact. Detailed assessments are still to be completed and the impact analysis has not have been completed for the 1st draft planning submission in December. It is imperative that L&SC system works to agree impact of opportunities for demand management and transformation to enable planning assumptions to be agreed and to inform key transformation programmes with clear links to WRP plans.ing due to be held on 9th January 2026.	Mitigation plans are not finalised (to be completed for M10)

Exit Criteria 2 – Progress Update



Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

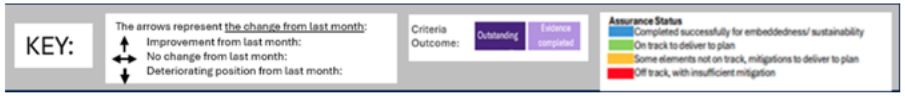
Exit Criteria (2):
Deliver quarter-on-quarter run rate improvement throughout 2025/26

Reporting Mechanisms:
- Quarterly regional reporting as part of Regional Support Group oversight
- Monthly IAG reports and meeting letters

Recommended Outcome:
Outstanding / In Progress

Criteria	Evidence required	Deliv ery	Risk	Deadline Date	Lead Exec SRO	Key update/escalations	Assurance gap reason
The organisation with deliver a quarter on quarter run rate throughout 2025/26.							
	Quarterly regional reporting as part of Regional Support Group oversight.	↔	↔	Quarterly reports to end of 25/26	Executive Director of Finance	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.2m in Q2, a £2m improvement, and a further improvement of £0.6m to £21.2m at Q2. Workstreams have all been assigned Executive SROs with accountability through the FIG. Grip and control processes in place and are currently being refreshed through the PMO and Executive SROs. Mitigation plans being developed to support WRP delivery.	Evidence of delivery incomplete / not yet due (M12 actual position to determine final assessment)
	Monthly IAG reports and meeting letters	↔	↔	Monthly updates to end of 25/26	Executive Director of Finance		Evidence of delivery incomplete / not yet due (M12 actual position to determine final assessment)
Robust expenditure controls in line with PwC recommendations.							
	Grip and Control cross-cutting workstream establishment	↑	↑	Monthly updates to end of 25/26	Executive Director of Finance	The Trust received the updated assessment of Grip and Control from PwC on 14th July 2025 It contained 112 recommendations – of which 88 were rated as red and amber (62 pay) The PMO co-ordinates updates against the plan and these are reported to F&P, People and Culture Committeee and Audit Committee. To date, the PMO has reported on actions completed but with very little focus on KPI development and measurement as well as evidence of delivery for assurance purposes. **Pay** – a full update on the new PWC actions has been provided to People and Culture Committee as part of the Workforce Update Paper. In addition, there are enhanced control processes established, including a daily variable pay control panel and weekly vacancy control panel. Both panels are fully operational with the PMO working with People and Workforce and Finance colleagues to ensure full evidence is captured moving forward. Analysis of the WTE numbers and associated finance is ongoing with good progress. Analysis from HR and finance colleagues to be provided shortly via the next IAG pack. Extension of current MARS scheme to be implemented to help address WTE targets. New job planning process has been implemented by the new Medical Director but remains in early stages. This process will cover team job planning but will also be considering demand and capacity as well as affordability. **Non-pay** – key actions underway as part of a new enhanced non-pay grip and control process are: Full investment case review has been undertaken and reported to Finance & Performance Committee. Non pay controls are now being strengthened as a result of the review and currently being reset follwoing 'handover' to the Executive Director of Finance. Contract database being reviewed and refreshed to ensure it is accurate. Good progress is being made in relation to drug spend and the switch to biosimilars is positive in comparison to other NHS trusts. More evidence is required to clearly illustrate this position which is being progressed by the Executive Director of Finance, the PMO and the divisions. SFIs have been reviewed and delegated limits were amended in March 25 to support financial recovery. Fewer people now have the ability to authorise or approve expenditure. Trust finance business partners continue to support trust colleagues in effective budget management. Establishment of non-pay working group to oversee implementation of enhanced grip and control measures inclusive of One LSC/Procurement (small key individuals). Non-pay Rapid Improvement Weeks initiated as of the 1st Dec 2025; a week in Burnley and a week in Royal Blackburn. Establishment of daily MDT non-pay panels to scrutinise all agreed aspects of non-pay based on requsition value PMO, and supportive NHS TU personnel, have roles identified to focus on non-pay grip and control operations. Core functions include the support of panels preparation summaries and output capture from an action completion summary and development of core KPIs. The outline plan will be for the 'live' Power BI reporting to be operational by February 2026. This timeline is inclusive of KPI development and reporting development. Ongoing management and ownership of grip and control processes remains with the PMO with accountable leadership via the Executive Director of Finance (non-pay) and the Director of People (variable pay / vacancy control panels).	N/A - Complete
	Enhanced Grip and Control measures	↑	↑	Monthly updates to end of 25/26	Executive Director of Finance		Evidence of delivery incomplete / not yet due (to be completed for M10)
	Response to PwC Grip and Control Recommendations	↑	↑	Monthly updates to end of 25/26	Executive Director of Finance		Evidence of delivery incomplete / not yet due (to be completed for M10)

Exit Criteria 3 – Progress Update

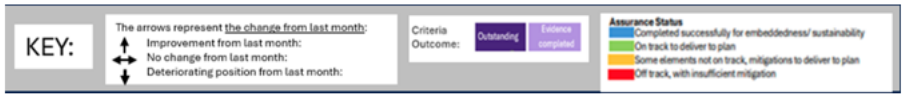


Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (3):	**Reporting Mechanisms:**	**Recommended Outcome:**
Develop a medium-term financial recovery plan covering the period post 2025/26	- Monthly IAG reports and meeting letters	**Outstanding / In Progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
A Board and IAG approved plan for financial recovery and maintenance beyond 2025/26 by the end of Q3							
	Clear planning process, timetable and assumptions in place to support agreement of medium-term plan	↓	↓	~~31/12/2025~~ Proposed new date to fit national planning timeframe: 31/03/26	Exec Director of Finance	The L&SC system is working together to support the medium-term planning process. 1st draft submissions were made on 16th December 2025. The 1st draft submissions reflected the planning ask for performance/activity including RTT and non-elective demand and in reflecting this in the financial submission it is recognised this creates a triangulation issue with the ICB on assumed income. Work is ongoing to ensure that demand management, commissioning intentions, provider productivity and provider demand management are developed to include in 2nd submission plans. Further work is required to develop the workforce plan and to develop detailed delivery plans for the waste reduction programme linked to key transformation opportunities at provider and system level. Board assurance statements have been scored to reflect the further work to be completed. The Trust has commissioned additional support via the Recovery Support Programme to assist in the development of its medium-term financial plan and this will commence in January 2026.	Evidence of delivery incomplete / not yet due (due to complete in M12)
	Engagement and robust review of commissioning intentions	↓	↓	~~31/12/2025~~ Proposed new date to fit national planning timeframe: 31/03/26	Director of Service Development & Improvement	Commissioning intentions review during 2025/6 complete. Commissioning intentions for 2026 onwards received and joint working underway between ICB and Providers. The PSC commissioned by the ICB to support quantification of commissioning intentions. Commissioning intentions and demand management assumptions were not included in 1st draft submissions. A further workshop is to be held on 9th January 2026 to progress next steps.	Evidence of delivery incomplete / not yet due (due to complete in M12)
	Financial plan including WRP plan for 26/27 by end of Q3, signed off by Board	↓	↓	~~31/12/2025~~ Proposed new date to fit national planning timeframe: 31/03/26	Exec Director of Finance	The Trust is committed to developing a financial plan to meet the control total set by NHSE and to return to financial balance within 3 years, however this will require further discussion with commissioners about contracted values for activity and growth. As per the approach agreed as the system, the Trust has assessed the activity that would be required to meet the planning ask. Work is now ongoing to ensure this is an affordable plan. The Trust is keen to work with commissioners to get to an agreed contractual value for the activity commissioned. Work continues to develop detailed plans for the Waste Reduction Programme in 2026/27. The Trust has commissioned additional support via the Recovery Support Programme to assist in the development of its medium-term financial plan and this will commence in January 2026.	Evidence of delivery incomplete / not yet due (due to complete in M12)
	Monthly IAG reports and meeting letters	↑	↑	Monthly	All Exec SROs	This will document discussions held at IAG by way of updates	N/A - Complete

Exit Criteria 4 – Progress Update

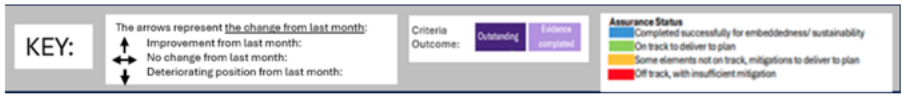


Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (4):	**Reporting Mechanisms:**	**Recommended Outcome:**
Demonstrate effective financial and organisational governance structures and mechanisms	Monthly IAG reports which identify participation in governance and leadership activity. By end of July presentation of a governance and leadership actions plan to the IAG and monthly review of progress.	**Outstanding / In progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
Development of an improvement plan to ensure timely response, evidence and completion of recommendations in the Governance Review of April 2025.							
	Monthly IAG reports which identify participation in governance and leadership activity.	↑	↑	Monthly	Director of Service Development & Improvement	Updates provided to IAG on a monthly basis, this will continue until the Trust exits RSP.	N/A - Complete
	Full improvement plan signed off by Board	↔	↔	01/09/25	Director of Service Development & Improvement	First draft of improvement plan reviewed at July Trust Board. Final draft of improvement plan approved at September Board meeting. Will remain a standing item at Board until the improvement plan is complete.	N/A - Complete
A Board/Improvement and Assurance Group agreed governance and leadership action plan in response to the recommendations of the Governance Review of April 2025, and following publication of the Seagry review outcomes							
	By end of July presentation of a governance and leadership action plan to the IAG and monthly review of progress.	↔	↔	end July 2025	Director of Corporate Governance	Governance and leadership action plan completed combining all previous reviews. Signed off at Trust Board on 28th July and submitted to IAG on 30th July. Draft Seagry 2 Report received and action plan updated to reflect the new recommendations and progress against Seagry 1 recommendations.	N/A - Complete
	Completion of recommendations in the Governance Review of April 2025	↑	↑	31/03/26	Director of Corporate Governance	There were 18 recommendations arising from the Governance Review (April 2025) resulting in 26 actions incorporated into the wider governance and leadership action plan. As of January 2026 18 actions are blue/complete, 7 are green/on track and 1 is red/behind deadline. The overarching Governance & Leadership Plan has 88 actions in total, as of January 2026 68 are blue/complete, 18 are green/on track. See Appendix 2 for the full action plan.	Evidence of delivery incomplete / not yet due (due for completion M12)
	Commission Wider Financial Governance Stage 2 review	↔	↔	end August 2025	Director of Corporate Governance	The second Seagry review has completed and recommendations presented to the Board on 10 September. There were 26 recommendations accepted and incorporated into overarching governance and leadership action plan. As of January 2026 14 actions are blue/complete, 11 are green/on track and 1 is red/behind deadline. See Appendix 2 for full action plan.	N/A - Complete
	Incorporate findings of wider financial governance review into the governance and leadership action plan once received	↑	↑	end September 2025	Director of Corporate Governance	The Trust leadership and governance action plan now incorporates recommendations from all reviews including the wider Governance Review from the Stage 2 Seagry review (Appendix 2).	N/A - Complete

Exit Criteria 4 – Progress Update

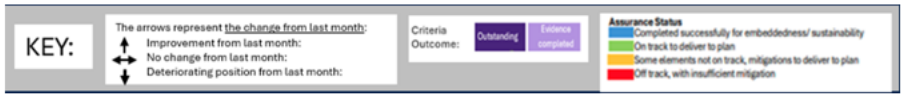


Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (4):	**Reporting Mechanisms:**	**Recommended Outcome:**
Demonstrate effective financial and organisational governance structures and mechanisms	Monthly IAG reports which identify participation in governance and leadership activity. By end of July presentation of a governance and leadership actions plan to the IAG and monthly review of progress.	**Outstanding / In progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
Evidence of full board engagement in an externally commissioned (Value Circle) Board development programme which addresses the recommendations of the leadership review undertaken by the interim Director of Governance, fostering unitary behaviours.							
	Value Circle programme commissioned and agreed. Phase 1 completed July 2025, phase 2 commenced.	↔	↔	10/09/2025	Director of Corporate Governance	Phase 1 of Board Development completed 31 July 2025. Phase 2 of Board Development agreed by the Board on 10 September 2025 and external partner Value Circle commissioned by the CEO.	N/A - Complete
	Value Circle Board Development Programme completed	↔	↔	30/06/2026	Director of Corporate Governance	Phase 1 Board development completed. Phase 2 programme agreed but delayed from commencing December 2025 to February 2026 due to Board changes.	Awaiting commencement of phase 2 (currently
Identification of financial and organisational risks and effective controls as evidenced in Board Assurance Framework and Risk Management processes and triangulation via Triple A reporting at subcommittee and Board level.							
	Board Assurance Framework reviewed and updated	↑	↑	30/09/25	Director of Corporate Governance	BAF risks for 2025/26 reviewed and updated and risk appetite statement agreed by Trust Board in April 25. Ongoing review and perpetual improvement. New format agreed at October Audit Committee to be implemented from Quarter 4.	N/A - Complete
	Risk Management Strategy reviewed and updated	↑	↑	31/10/25	Medical Director	Risk Management Framework and Strategy and approved at Audit Committee in October.	N/A - Complete
	Corporate Risk Register reviewed and updated	↑	↑	30/09/25	Medical Director	Initial review completed and risk register and CRR completely overhauled. Ongoing meetings with Risk owners to review and update CRR risks. Executive Risk Assurance Group where the CRR is considered now formally reports to Audit Committee. Ongoing review and perpetual improvement.	N/A - Complete
Management of executive team vacancies in line with agreed ICB change programme mandates and through notification to and involvement with the NHS England regional team.							
	Evidence of due process as required for any recruitment	↑	↑	Ongoing	Director of Corporate Governance	Medical Director appointment completed in line with process. Interim Chief People Officer completed in line with process.	N/A - Complete
Demonstrable assurance that any risk to quality and patient safety through the delivery of CIP's is mitigated.							
	Review of QIRA process	↑	↑	31/10/25	Chief Nurse	Review of QIRA process underway.	N/A - Complete
	Evidence of QIRA reviews via Quality Committee	↑	↔	31/10/25	Chief Nurse	QIRAs are reported to Quality Committee. Review of role of Quality Committee to strengthen oversight to be undertaken on back of QIRA process review.	Evidence of delivery incomplete / not yet due (to be completed in M10)

Exit Criteria 5 – Progress Update



Assurance gap reasons:
N/A - Complete
Evidence of delivery is incomplete / Not yet due;
Mtigation plans are not finalised
Reporting shows adverse variance

Exit Criteria (5):	**Reporting Mechanisms:**	**Recommended Outcome:**
Full participation in the financial recovery support programme	- Monthly IAG reports which identify participation in the RSP	**Outstanding / in progress**

Criteria	Evidence required	Delivery	Risk	Deadline Date	Exec SRO	Key update/escalations	Assurance gap reason
Executive Board attendance at monthly Improvement and Assurance Group meetings.							
	Attendance at IAG	↔	↔	31-Mar-26	Full Board	Ongoing attendance at IAG, which will continue until the Trust exits RSP.	N/A - Complete
Engagement with the Turnaround Director and associated support executive team and response to requested actions including monthly reporting, financial planning and specific project deliverables.							
	Proactive engagement with PwC Central team	↑	↑	31-Mar-26	Full Board	IAG pre-meets, ongoing PID reviews, ongoing developing of reporting	N/A - Complete
	Regular meetings with System Turnaround Director	↔	↔	31-Mar-26	Full Board	Ongoing attendance at IAG, which will continue until the Trust exits RSP.	N/A - Complete
Timely and accurate reporting of financial data.							
	Detailed financial data available at Finance and Performance Committee and Trust Board. Detailed financial review through improved governance meetings.	↑	↑	31-Mar-26	Exec Director of Finance	Financial data reporting has been improved at both IAG and F&P and Trust Board. Detailed review of data is completed at the newly established Financial Oversight Group and Financial Improvement Group. Work is ongoing to improve the timeliness of papers to be circulated for F&P.	N/A - Complete
Establishment of a trust wide Project Management Office (PMO) function and appointment of Senior Responsible Officers (SROs) to manage delivery of financial and organisational plans.							
	Establishment of PMO function	↑	↑	31-Mar-26	Director of Service Development & Improvement	PwC instructed to support PMO function from April to August 2025. PMO now staffed from internal resources in support of financial recovery in the Trust. Establishment of PMO is progressingwith a furtherfull review has been undertaken in October. New support for the PMO has been identified and commenced from 3/11/25 with support from the NHS Transformation Unit. PwC have conducted a 'critical friend' review of the finance recovery programme and recommendations are being implemented. Next steps is ongoing maturity of the PMO. continued improvements to reporting and ongoing work to align to the Improvement Hub Team.	Evidence of delivery incomplete / not yet due (intention to complete for M10)
	Appointment of SROs to manage delivery of financial and organisational plans	↑	↑	31-Mar-26	Director of Service Development & Improvement	Cross cutting workstreams established including ToR and alignment to financial delivery and WRP delivery. Each workstream has an identified Executive SRO, PMO link, clinical link and operational leads. The Finance Improvement Group, chaired by the CEO, will hold executive SROs to account for delivery - this meets fortnightly. Further work ongoing to mature the cross-cutting workstreams and associated reporting.	N/A - complete

Regulatory Undertakings - Progress Summary November 2025

All Exit Criteria link to the Regulatory Undertakings. The table below provides a summary of updates at Month 8. There is a detailed breakdown of updates against each sub-section of the undertakings with cross referencing of relevant evidence and exit criteria as part of the RSP Exit Criteria Supporting Plan.

Undertaking Focus	Key Actions	Delivery	Risk	LEAD Exec SRO	Key Update/Escalations
Financial Planning					
	1. Within a timeframe set by NHS England, the Licensee will agree a 2025/26 Financial Plan with NHS England.	↑	↑	Chief Executive	The financial plan has been agreed with Trust Board and with NHS England
	1.2 The Licensee will deliver a quarter-on-quarter run rate improvement from Quarter 4 2024/25 and throughout 2025/26.	↔	↔	Exec Director of Finance	There has been a quarter-on-quarter run-rate reduction since Q3 24/25. The Q1 normalised position has reduced from £23.2m in Q4, down to £21.2m in Q2, a £2m improvement. The focus for the Trust needs to be to reduce costs recurrently and in turn reduce the underlying deficit into 26/27.
	1.3 The Licensee will comply with all documented actions required by the System Financial Turnaround Director through the IAG.	↑	↔	Chief Executive	All documented actions through IAG have been completed on a monthly basis.
Recovery Support Programme					
	2.1 The Licensee will evidence all reasonable steps have been taken to meet the Recovery Support Programme (RSP) Exit Criteria as set out and agreed by the IAG, in accordance with the timescales agreed by the IAG.	↑	↔	Director of Service Development & Improvement	An improvement plan has been presented to Trust Board in July 2025 and further iterated with support of the national RST lead. This is now monitored monthly and updated with progress. Formal reporting to IAG and NHSE is in place. The Trust will now work with RSP, NHSE Region and ICB in agreeing a Single Improvement Plan.
	2.2 The Licensee will carry out a review of progress against the RSP Exit Criteria and report to the IAG, in accordance with the timescales agreed by the IAG.	↑	↔	Director of Service Development &	The updated Improvement Plan is being presented at relevant Trust committees for sign off and to the IAG.
	2.3 In line with the IAG Terms of Reference and the requirements of the NHS Oversight Framework segmentation, the Licensee will cooperate fully with NHS England, health sector stakeholders and any external agencies or individuals appointed to work with or support the Licensee to address the concerns which these undertakings seek to address.	↔	↔	Chief Executive	There has been significant engagement with NHSE leads as we develop our exit criteria plan and improvements required. The Trust works collaboratively with partners including the ICB and through the IAG to provide assurance on progress. The Trust will now work with RSP, NHSE Region and ICB in agreeing a Single Improvement Plan.

Regulatory Undertakings – Progress Summary November 2025

KEY:

The arrows represent the change from last month:
- ↑ Improvement from last month:
- ↔ No change from last month:
- ↓ Deteriorating position from last month:

Criteria Outcome: Outstanding | Evidence completed

Assurance Status
- Completed successfully for embeddedness/ sustainability
- On track to deliver to plan
- Some elements not on track, mitigations to deliver to plan
- Off track, with insufficient mitigation

Undertaking Focus	Key Actions	Delivery	Risk	LEAD Exec SRO	Key Update/Escalations
Leadership & Governance					
	3.1 The Licensee will co-operate and engage as required with the "Governance and Leadership Review" initiated by NHS England and led by an NHS England appointed Improvement Director.	↔	↔	Director of Corporate Governance	Governance Review completed April 2025. Findings and recommendations endorsed by NHSE Improvement Director and accepted by the Board. Our governance and leadership action plan combines recommendations from all reviews completed. Recommendations are well in progress with more
	3.2 The Licensee will ensure that it has in place sufficient and effective Board and management leadership capacity and capability, as well appropriate governance systems and processes to enable it to: 3.2.1 comply with the undertakings at paragraphs 1 and 2 effectively; and 3.2.2 address any other issues relating to governance or operations that have caused or contributed to, or are causing or contributing to, or will cause or contribute to, the breach of the conditions of the Licensee's licence	↔	↔	Director of Corporate Governance	A Board leadership and governance action plan is in place incorporating the second Seagry review. Phase 1 Board development completed. Phase 2 Board developed agreed and commissioned to commence Dec 2025 (once new Chair joins) – June 2026. Additional RSP funding secured to support the delivery of the G&L Action Plan. New Chair appointed by NHSE to commence 6 Dec 2025, succession planning for the NEDs will be a priority for the new Chair.
	3.3 The Licensee will inform NHS England prior to recruitment to executive board level posts and will (a) share the relevant person specifications with NHS England in draft for NHS England's comment. (b) provide a timetable for the appointment, and (c) ensure that there is NHS England representation on the interview panel.	↑	↑	Director of Corporate Governance	There has been appropriate involvement of the ICB and NHSE in the appointment of the Executive Medical Director and Interim Director of People and Culture (shared arrangement with Lancashire Teaching Hospitals NHS Trust). Board succession planning paper to Sept Rem Comm. Recruitment will commence for a new DIrector of Finance to support succession planning
Funding Conditions and Spending Approvals					
	4.1 Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee under Schedule 5 to the National Health Service Act 2006, the Licensee will comply with any terms and conditions which attach to the financing.	↑	↑	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activities.
	4.2 The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to schedule 5 to the NHS Act 2006.	↑	↑	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activities.
	4.3 The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England.	↑	↑	Exec Director of Finance	The Trust has complied with all requirements in respect of approvals for external consultancy support for financial recovery activities.
Meetings & Reports					
	5.1 The Licensee will provide regular reports to NHS England through the IAG on its progress in meeting the undertakings set out above.	↑	↑	Director of Service Development &	The Trust provides detailed reports to the IAG and evidence is provided for review.
	5.2 The Licensee will attend monthly IAG meetings, or, if NHS England stipulates, conference calls, as required, to discuss its progress in meeting those undertakings. IAG meetings will be led by the System Financial Turnaround Director, with attendees specified by NHS England.	↑	↑	Chief Executive / all Exec SROs	IAGs have been attended by the Executive team or appropriate deputy. They are chaired by the System Financial Turnaround Director.
	5.3 The Licensee will provide NHS England with the assurance relied on by its Board in relation to its progress in delivering these undertakings, upon request.	↑	↑	Director of Service Development &	A detailed improvement plan and progress reports are provided through IAG and as requested. A joint Sharepoint has been established in August 2025 to share evidence and provide assurance to NHSE leads.
	5.4 The Licensee will comply with any additional reporting or information requests made by NHS England.	↑	↑	Director of Service Development &	No additional requests at this time

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/012
Report Title:	Maternity and Neonatal Services Update		
Author:	Tracy Thompson, Divisional Director of Midwifery and Nursing (Maternity Safety Champion) collectively informed by Perinatal Transformation Team & Perinatal quadrumvirate team.		
Lead Director:	Peter Murphy, Executive Director of Nursing. Board Level Maternity/Neonatal Safety Champion.		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓	✓	✓	✓
Executive Summary:	The purpose of this report is to provide: • Assurance on quality and safety programmes within maternity and neonatal services aligned to the National Perinatal Safety Ambitions and the ten CNST MIS Year 7 safety actions. • An update on ELHT's response to the Maternity and Neonatal Three-Year Delivery Plan (reported bi-monthly via Quality Committee, with escalation to Trust Board by exception). • Escalation of any safety intelligence identified through the NHSE Perinatal Quality Oversight Model that may pose a risk to safe care delivery. • Assurance of progress against continuous service improvement, using a "what good looks like" approach.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board of Directors is asked to: • Receive and note the CNST MIS Year 7 update and compliance position. • Discuss any identified safety concerns or delivery barriers, informed by Floor to Board reporting and Safety Champion oversight. • Provide advice and guidance on maternity and neonatal safety issues, including agreed actions, timescales, and mitigations where required.			

Previously Considered by:	
Date:	
Outcome:	

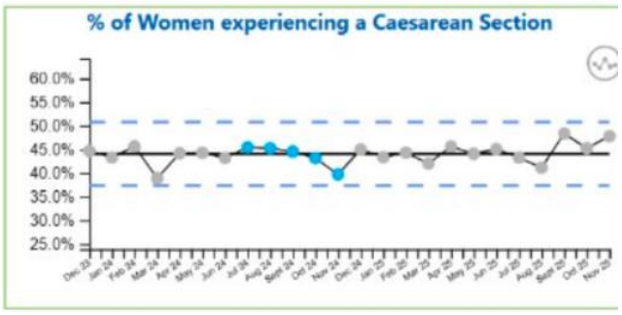
1. MATERNITY AND NEONATAL PERFORMANCE DATA – EXCEPTIONS

1.1 Maternity SPC Report

1. The FCCG Information & Performance Manager has developed a dashboard demonstrating data in Statistical Process Control (SPC) chart format (**Full report - Appendix 1**). The data is refreshed on the first week of every month, providing data for the month previous. This is analysed for emerging trends and outliers initially by the Information & Performance Manager and Transformation Programme Manager. An exceptions report is produced. Following this the report is a standard agenda item at the FCCG Maternity and Neonatal Data & Digital Group and further the Divisional Management Board.

2. The November 2025 exception report (**Appendix 2**) highlights:
    - A statistically significant reduction in induction of labour rates (36% in November 2025 compared with a 24-month average of 42%).
    - Statistically significant variation in APGAR scores <7, clinical rationale and assurance are provided in the exceptions report.
    - Continued assurance regarding reduced rates of 3rd/ 4th degree tears and term admissions to NICU.

3. Clinical Director of Obstetrics Mr Martin Maher has provided detail to inform Trust Board of the wider understanding regarding raised C-Section rates nationally, as below and included in the exception report:



Over the past decade there has been a marked rise in C-section births across England, a change that is reflected within the catchment served by East Lancashire Hospitals NHS Trust. In 2023–24, data shows that about 42 % of all births in NHS hospitals in England were delivered by caesarean section — a steady rise over the past ten years.

This rising CS rate is reflected in all providers within the ICB. East Lancashire is not an outlier. Datasets demonstrate that although the overall caesarean section rate is rising, the elective section rate is rising around a faster rate than emergency rates, which is steady. The crude total

number of caesarean births is also increasing given an increasing birth rate overall at ELHT (approx. additional 200 bookings each year).

Several interrelated factors contribute to this increase, which mirror broader national shifts in maternal health and obstetric practice. First, there are demographic and medical population changes: many births now involve more complex pregnancies, often because mothers are older, and there are higher rates of maternal obesity and associated health conditions. These factors raise the clinical risks of labour — for example, complications such as placental problems or fetal distress — which can make surgical delivery more likely or safer than prolonged labour.

Second, evolving professional guidance and policy have reshaped how decisions about mode of birth are made. In 2022, NHS England formally instructed all maternity services to abandon "normal birth" or C-section rate targets — previously many hospitals had been encouraged to aim for roughly 20 % C-section births. This change recognised that rigid targets could be unsafe, pressuring clinicians to avoid caesareans even when clinically indicated.

In place of targets, guidance from National Institute for Health and Care Excellence (NICE) supports the principle that mode of delivery should be determined on an individual basis — including offering a planned C-section when requested by a fully informed woman, even in the absence of a strict medical indication. This shift thus likely contributes to increased elective (planned) sections, reflecting respect for maternal choice and improved shared decision-making.

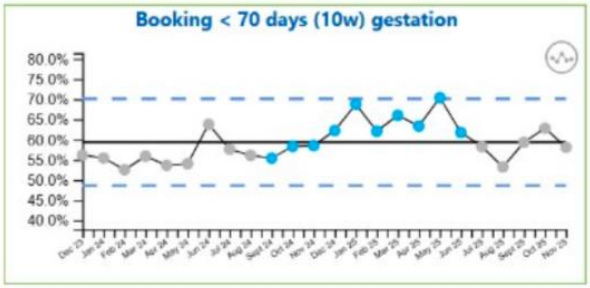
Taken together, these changes in population risk, clinical judgment, and policy may lead ELHT to see a rising share of births by caesarean. Rising rates of interventions in labour overall may influence the trend: as inductions of labour become more common, and as births are more often medically managed, the threshold for recommending a C-section may be lower than in earlier eras. Indeed, recent audits note that over half of births in the UK now involve some form of medical intervention (C-section or instrumental delivery).

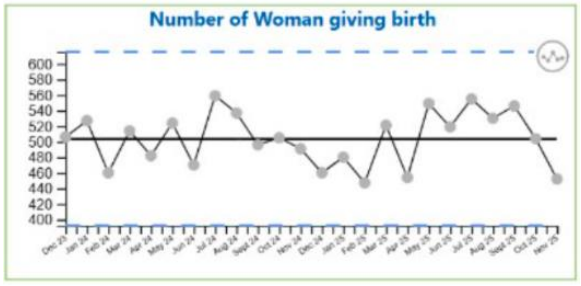
The socioeconomic demographic of East Lancashire means that there are higher rates of poor maternal health and fetal concerns. Higher prevalence of conditions such as diabetes in pregnancy, hypertension, fetal growth restriction, and fetal anomalies that are carried through pregnancy to term. This translates to increased medical intervention and caesarean section birth in this population to improve perinatal outcomes.

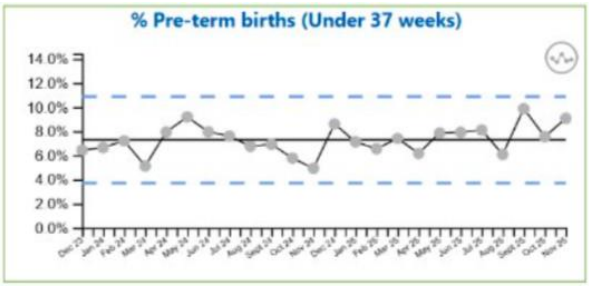
In summary:

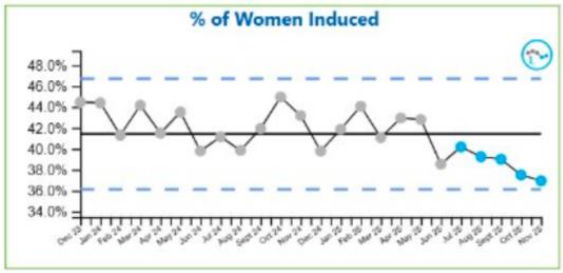
- Increasing birth rate at ELHT overall translates to increasing total number of CS births
- Increasing complexity of obstetric patients leading to higher rates of intervention
- National policy promoting a move away from lowering CS rate targets and towards increasing maternal birthing choice
- Increasing interventions in labour, such as increasing inductions of labour aligned to national guidance aimed at reducing stillbirth, translates into more complex labours and higher rates of caesarean birth.
- Socioeconomic status & core demographic factors within East Lancashire footprints prompts increased intervention and CS rates due to poor maternal health and higher rates of fetal concerns, e.g. fetal growth restriction, gestational diabetes, hypertension being some of the reasons requiring intervention.

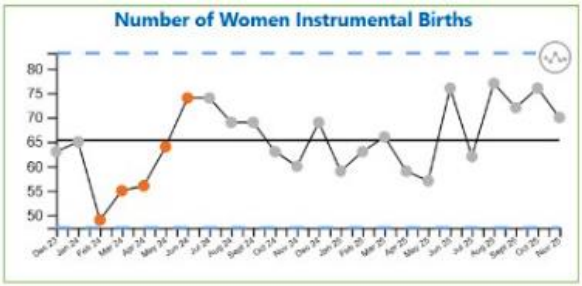
Further key data charts are demonstrated below:

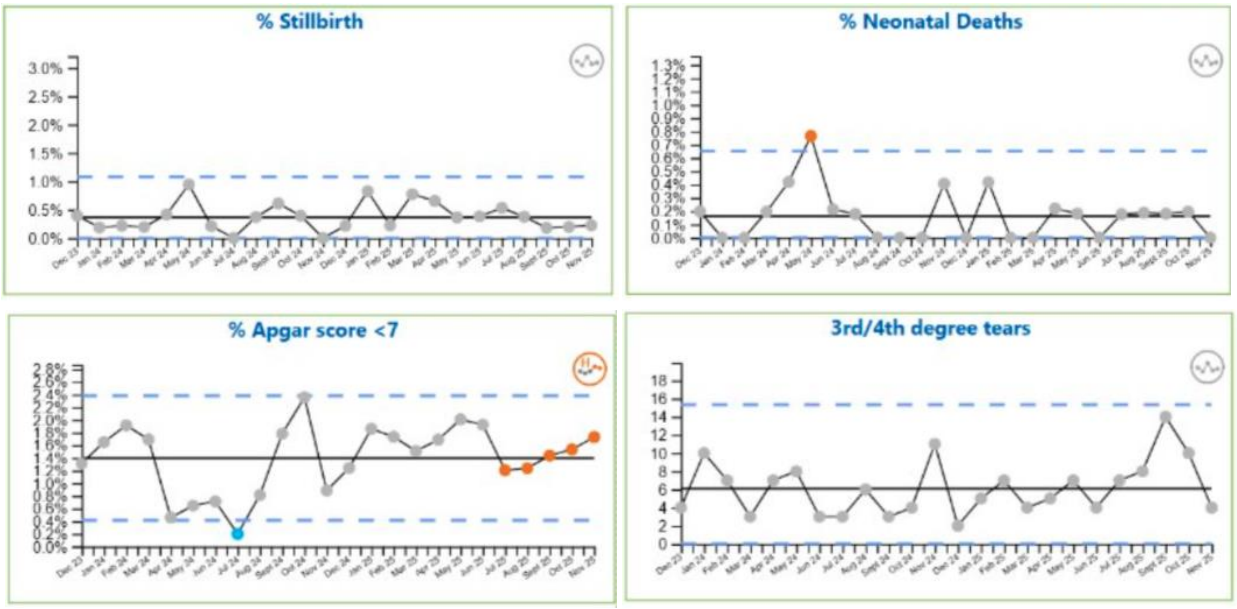












1.2 NW ODN - Neonatal Quarterly Dashboard

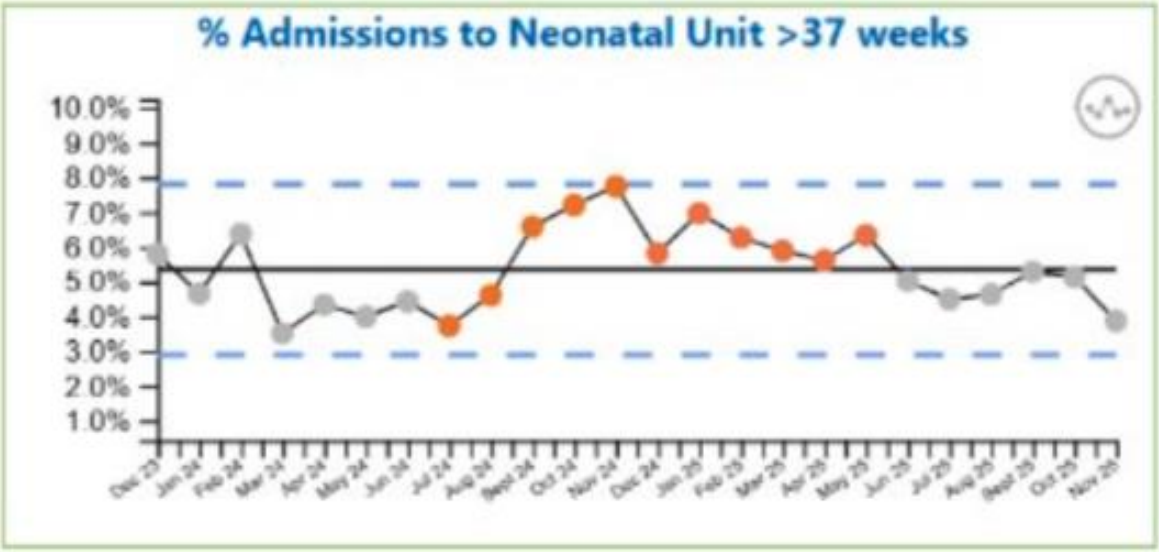
The Northwest Operational Delivery Network (NW ODN) has developed the Neonatal Quarterly Dashboard which includes activity and transfer data across the NW ODN such as unit closures and a range of clinical and outcome measures to allow comparison of activity with national benchmarks, this is inclusive of the National Neonatal Audit Programme (NNAP) measures.

The dashboard currently shows data up until September 2025. Please note for reference whilst reviewing alongside any data measures also provided in the above locally created SPC report as this is updated to November 2025.

The NW ODN dashboard demonstrates improvement in term admissions to NICU, aligning with reductions seen in the local SPC data. This provides external validation of the Trust's improvement trajectory.

Network Name	Unit Level	Location Name
LSC	NICU	Burnley

		25/26 Q2
Term admissions - percentage of NNU first admissions	ATAIN Visual	47.1%
Term admissions - percentage of term births (37wk+)	ATAIN Visual	4.9%
Term admissions - percentage of live births	ATAIN Visual	4.5%



The data below is provided on the NW ODN quarterly dashboard and demonstrates the instances where the Neonatal Unit has been closed to external admissions:

Closed to External Admissions
Rolling 4 Quarters

	24/25 Q3	24/25 Q4	25/26 Q1	25/26 Q2	Mean
APH	10	0	4	1	4
COC	0	0	0	0	0
ECH	2	0	1	0	1
LNP - LWH	6	3	0	3	3
MCHT	0	1	1	0	1
MWL - ODGH	2	4	17	5	7
MWL - STHK	11	1	8	12	8
WHH	5	1	2	0	2
MFT - NMGH	1	0	0	0	0
MFT - SMH	6	20	6	14	12
MFT - WYTH	0	2	0	7	2
RBH	0	6	38	1	11
ROH	10	8	2	8	7
SHH	0	0	0	0	0
TGH	0	1	0	0	0
WWL	1	8	6	1	4
BTH	1	2	11	2	4
ELHT	5	2	2	5	4
LTHTR	1	3	0	0	1
MBHT - FGH	2	0	7	1	3
MBHT - RLI	3	0	3	2	2

1.3 Data Management Processes

Divisional data management processes are in place to ensure data quality issues are highlighted and rectified via discussion at perinatal data & digital group, prior to exceptions and themes being reported through the division via Bimonthly Perinatal Governance Board and Divisional Management Board.

The Transformation Team work alongside Maternity and Neonatal clinical teams to implement any improvement work identified through this data management process. This process ensures QI projects are data informed, and clinician time and resource is directed to priority pieces of work.

2. NORTHWEST NEONATAL OPERATIONAL NETWORK (NWNODN) VISIT

The NWNODN annual visit to Burnley NICU in July 2025 provides external assurance, highlighting strong leadership, collaborative working, and commitment to quality improvement. An overview of the report is as below, and the full report will be submitted to the Trust Board once the definitive version is received.

Burnley remains a Level 3 NICU with 34 cots, achieving notable successes including:

- Level 3 Baby Friendly Initiative re-accreditation
- Family integrated Care sustainability
- Improved survival rates for extremely preterm infants
- National recognition for research and education initiatives

Key challenges include:

- Workforce gaps in Allied Health Professionals (AHPs), psychology, and radiology
- 24-hour Transitional Care staffing model
- Risks such as infection control issues, lack of Electronic Prescribing and Medicines Administration (EPMA), obsolete Retinopathy of Prematurity (ROP) equipment, and neonatal care gaps at Blackburn

The report notes the discontinuation of VCreate due to concerns over future-proof funding. The clinical team further advise that the chosen software, Badger net Diary, receives positive feedback from staff and parent users. The regional team recommended collecting enhanced parent engagement and feedback to support the Trust's rationale for its adoption.

Recommendations cover both immediate and longer-term actions, including:

- Developing a business case for 24/7 Transitional Care
- Strengthening AHP, psychology, and radiography provision
- Reviewing rectal swab processes for infection control
- Implementing standardised infusion protocols by March 2026
- Enhancing parent feedback mechanisms

Strategic support is essential to ensure compliance with national standards and achieve optimal outcomes for babies and families.

ELHT Neonatology department has been managing a recent infection control outbreak, containment and control measures following a series of interdisciplinary meetings have been enacted. A review and prevention approach to reduce reoccurrence's is underway to be demonstrated with evidence at ELHT infection prevention and control committee and Trust wide quality governance meetings.

3. CNST – MATERNITY INCENTIVE SCHEME

3.1 Summary overview

Blue indicates sign-off for the CNST period by LMNS received

Green indicates progressing without concern

Orange indicates barriers/ risk to compliance identified

Red indicates non-compliance identified

ELHT is on track to meet all ten CNST Maternity Incentive Scheme Year 7 safety actions, with LMNS sign-off received or expected for each action, and no unresolved areas of non-compliance identified at the time of reporting.

Any emerging risks to CNST compliance are escalated through the Perinatal Governance Board and Floor to Board meetings, with immediate notification to Executive and Non-Executive Board-level Safety Champions and, where required, the Trust Board.

Safety Action	Progress	Assurance/Exceptions
1. Perinatal Mortality Review Tool (PMRT)		● We are within required time limits for all metrics for deaths of babies within the Y7 period as per guidance.
2. Maternity Services Data Set (MSDS)		● The July scorecard has been published and shows compliance.
3. Transitional Care (TC)		● Annual Transitional care (TC) audit will be submitted to January 2026 Trust Board. ● The Jaundice Quality improvement has been presented to the Board Level Safety Champions in October 2025.
4. Clinical Workforce		● Neonatal nursing workforce pressures – mitigated through an agreed action plan and CNST-compliant staffing oversight. ● Following further review, the Neonatal Medical Workforce is now compliant with BAPM standards for tiers 1, 2 and 3.
5. Midwifery Workforce		● Birthrate+ exercise is due for renewal this CNST year to maintain compliance. Submission of all required data has been made. Awaiting the final report. ● Current funded midwifery establishment does not reflect the 2022 Birthrate + findings and recommendations. Plan/mitigations are reflected in biannual midwifery staffing reports which ensures SA5 compliance.
6. Saving Babies Lives v3 Care Bundle (SBLv3)		● ELHT are currently at 97% overall implementation following the LMNS assurance visit in November 2025.

		● Further progress and sustainability of current implementation plan with associated actions continues with close oversight from Obstetrics Clinical Director/Perinatal Quadrumvirate.
7. User Feedback		● Evidence of progress with a co-produced action plan in response to the 2025 CQC survey in place. ●MNVP capacity constraints – mitigated through LMNS escalation, gap analysis, and interim engagement arrangements
8. Training		● Previously reported training compliance dips – mitigated through targeted recovery plans and ongoing monitoring.
9. Board Assurance		● An update on progress with the Culture Improvement Plan was included in September Trust Board report. Culture coach session feedback has been reviewed for themes and continues to be discussed by the quadrumvirate. ● Triangulation of claims, incidents, and complaints was presented to the Floor to Board meeting in October 2025
10. MNSI (Maternity and Newborn Safety Investigation) / NHS Resolution		● Quarterly MNSI reports are submitted to Trust Board. ● Year 7 guidance requires that MNSI information be provided to patients in a format that is accessible to them. Any exceptions to this are to be reported to Trust Board.

3.2 Key updates and exceptions per Safety Action

3.2.1 Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

The Perinatal Mortality Review Tool (PMRT) dashboard below demonstrates that all metrics have been met for CNST Year 7: deaths that occurred from 1 December 2024 to 30 November 2025.

CNST - PMRT
(All measures reported against month of death)

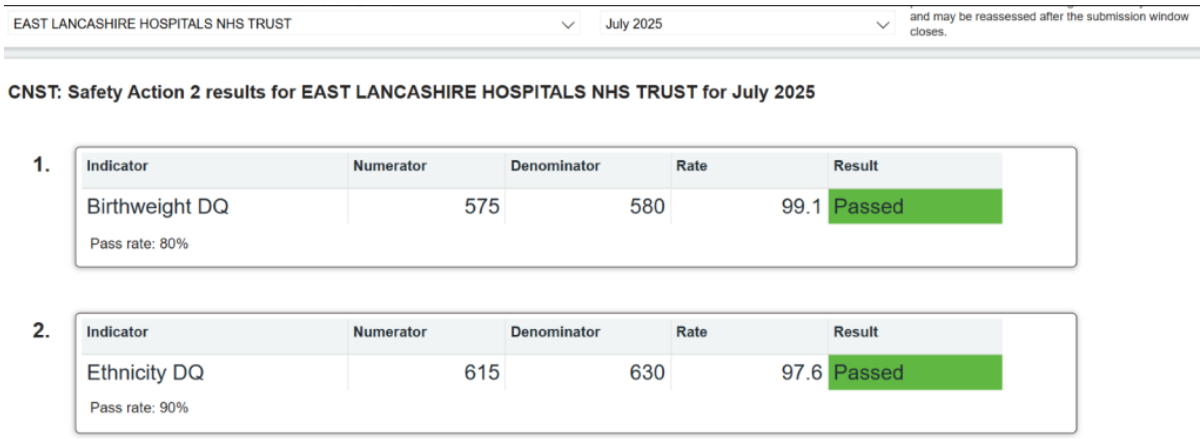
* = Data not relevant for month
n/a = Data not available at time of report

		Reporting Measure	Threshold	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
SAFETY ACTION 1	PMRT01a	Total Number of Stillbirths (= 24 weeks)		2	3	1	4	3	1	1	2	2	3	2	1
	PMRT 01b	Number of Neonatal Deaths		1	2	0	0	1	0	0	1	1	1	1	0
	PMRT01 c	Number of late fetal loss between 22+0 and 23+6 weeks		1	0	0	1	0	0	0	0	0	0	0	0
		Total Eligible Cases		4	5	1	5	4	1	1	3	3	4	3	1
	PMRT02a	a) i Number of cases reported to MBRRACE within 7 days		4	5	1	5	4	1	1	3	3	4	3	1
			100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	PMRT06a	c) i Number PMRT tool started 2 months		4	5	1	5	4	1	1	3	3	4	3	1
			95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	PMRT05a	c) ii Number PMRT published reports by 6 months		4	5	1	4	4	1	1	2	0	0	0	0
			75%	100.0%	100.0%	100.0%	*	100.0%	100.0%	100.0%	66.7%	*	*	*	*
	PMRT05 c	Number PMRT published reports not due		0	0	0	0	0	0	0	1	3	4	3	1
	PMRT05d	Number PMRT with External Member Present *monitored from Apr-25 deaths onward		n/a	3	0	5	3	1	1	2	0	0	0	0
			50%	n/a	60.0%	0.0%	100.0%	75.0%	100.0%	100.0%	66.7%	*	*	*	*

Please note that the metric for external member present at PMRT meetings was only introduced for deaths from April 2025 onwards, and the report currently outstanding for a death in July

2025 (as highlighted above in red) is **not yet due**, rather than non-compliant, as detailed on the dashboard.

3.2.2 Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?



EAST LANCASHIRE HOSPITALS NHS TRUST | July 2025 | and may be reassessed after the submission window closes.

CNST: Safety Action 2 results for EAST LANCASHIRE HOSPITALS NHS TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	575	580	99.1	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	615	630	97.6	Passed

Pass rate: 90%

The 'Clinical Negligence Scheme for Trusts: Scorecard' in the Maternity Services Monthly Statistics publication series, as above, publishes each month and is used to evidence compliance with the data quality measures required for this safety action.

July 2025 is the month submitted to evidence MIS Year 7 compliance. July results as above show compliance and therefore sign-off of this safety action which has been acknowledged by the LMNS during the November 2025 CNST visit.

3.2.3 Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

The service has now moved towards an annual TC audit, meaning that the next audit covering the MIS Year 7 reporting period will be completed in January 2026 and findings submitted to Trust Board in March 2026, as registered and monitored via the Trust Clinical Audit & Effectiveness team.

This safety action is acknowledged as compliant with LMNS sign off as per LMNS November 2025 visit and detail included in previous iterations of this report.

3.2.4 Safety action 4 – Can you demonstrate an effective system of clinical workforce planning to the required standard?

All requirements of this safety action have been met and provided to Trust Board throughout the CNST Year 7 reporting period including:

- Obstetric Workforce Locum Audits (detail within the November 2025 report)
- Obstetric Workforce Consultant Attendance audit (detail within the Nov 2025 report)
- Anaesthetic workforce duty rota May-June 2025 submitted to evidence compliance to ACSA standards as reviewed during LMNS visits.
- Neonatal Medical Workforce report demonstrating compliance to BAPM standards (detailed in September 2025 report)
- Neonatal Nursing Workforce report and action plan (detailed in November 2025 report)

3.2.5 Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

All requirements of this safety action are met, and details have provided to Trust Board throughout the CNST Year 7 reporting period within earlier iterations of this report including:

- Assurance of midwifery safe staffing levels through monthly reports, actions to mitigate shortfalls evidenced.
- Birthrate+ three-year review assessment – completed in December 2025, the next bi-annual report will be presented at Trust board in March 2026
- Business case with revised action against 2022 birthrate+ findings for funded establishment for unfunded specialist midwifery posts to be reflected in the biannual report
- ELHT are now funded to all midwifery Clinical posts to fulfil birth rate plus recommendations from September 2022

3.2.6 Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three (SBLv3)?

A quarterly review of the 6 elements of Saving Babies' Lives (SBL) was conducted on the 4th of November 2025. Compliance increased to 67/69 interventions implemented overall, which equates to 97%. A breakdown of elements is provided below.

SBL Element	Current Implementation (as assured by LMNS)
Element 1 - Reducing Smoking in Pregnancy	9/10 interventions implemented and evidenced **(90%)**
Element 2 - Fetal Growth Restriction	20/20 interventions implemented and evidenced **(100%)**

Element 3 - Reduced Fetal Movement	2/2 interventions implemented and evidenced **(100%)** [1 intervention contains 4 asks]
Element 4 - Effective Fetal monitoring during labour	5/5 interventions implemented and evidenced **(100%)**
Element 5 - Reducing preterm births and optimising perinatal care	25/26 interventions implemented and evidenced **(92%)**
Element 6 - Management of Diabetes in Pregnancy	6/6 interventions implemented and evidenced **(100%)**

Further review meetings are scheduled throughout the CNST Y7 reporting period as follows:

a) 13th January 2026 (Quarter 3, sign off)

3.2.7 Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

All requirements of the Trust are met for this safety action, as detailed in the November 2025 Trust Board report. With the support and direction of the LMNS, ELHT has escalated that the current infrastructure of the Maternity and Neonatal Voice Partnership (MNVP) is no longer fit for purpose. In response, the LMNS is undertaking a gap analysis against national guidance and requirements, which will inform a risk assessment and action plan.

As a result, ELHT is not currently required to provide formal evidence of MNVP involvement in safety and governance meetings or evidence of wider MNVP engagement with the local community. However, assurance can be given that these activities continue at a level proportionate to the current capacity of the MNVP leads. MNVP lead representation is maintained at the bi-monthly Floor to Board meetings alongside maternity and neonatal safety champions (see Safety Action 9) and at the Perinatal Governance Board. Updates on safety and quality matters are also shared at the quarterly MNVP meeting (minutes provided in **Appendix 3**).

The MNVP Engagement Lead continues to attend community settings to engage with women and families. A live feedback tracker is in place, accessible by both MNVP and ELHT, to enable feedback to be recorded and acted upon. The LMNS, alongside Healthwatch as the host organisation, is reviewing how feedback is recorded and communicated to Trusts to strengthen this process.

The action plan arising from the 2024 CQC maternity survey continues to be closely monitored and progressed through MNVP co-production. The most recent update is provided in **Appendix 4.**

3.2.8 Safety action 8: Can you evidence the 3 elements of local training plans and 'in-house', one day multi professional training?

Fetal monitoring and surveillance (in the antenatal and intrapartum period) training: *90% attendance required for midwives, obstetric consultants and all other obstetric doctors who contribute to the obstetric rota.* All relevant staff groups are achieved over 90% compliance.

Maternity emergencies and multi-professional training (PROMPT): 90% attendance for obstetric consultants and doctors, midwives, maternity support workers, and anaesthetic consultants. Obstetric consultant and doctors were previously reported at 86% compliance, and a risk to CNST compliance. This was escalated and actions put in place, and we can give assurance that as of November 2025 this reached 95% compliance. All relevant staff groups are currently over 90%.

Neonatal basic life support (NLS): 90% attendance required for neonatal consultants, junior doctors (who attend any births unsupervised), neonatal nurses (who attend any births unsupervised), advanced neonatal nurse practitioners, and midwives. All relevant staff groups are achieved over 90% compliance.

3.2.9 Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Quality and Safety Reviews – Floor to Board meetings with all safety champions

Board-level safety champions have met with maternity and neonatal safety champions and the perinatal leadership team on a bi-monthly basis through the CNST Year 7 reporting period via Floor to Board meetings, held on:

- 19 April 2025
- 16 June 2025
- 7 August 2025
- 2 October 2025
- 12 December 2025

Minutes from the most recent meeting are provided in Appendix 5.

Actions arising from these meetings are documented within the minutes, and minutes from earlier meetings have been submitted to the Trust Board through previous iterations of this report. Together, these demonstrate the escalation of maternity and neonatal safety issues to Board-level safety champions, and the responses, support, and oversight provided.

The Trust Board is asked to acknowledge this assurance within the Trust Board meeting minutes.

Perinatal Quality Surveillance Model (PQSM) Minimum Data Set November 2025 data:

CQC Metric Ratings	Overall	Safe	Effective	Caring	Well led	Responsive
	Good	Good	Good	Good	Good	Good
On the maternity improvement programme?		No				

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Perinatal Data: August 2025
All metrics within the perinatal data has been specifically reviewed against the Maternity Scorecard Data, ensuring all data is collated in the same way and enhancing data quality.

Stillbirth rate:
There have been 5 stillbirths in this period – 2 in September 1 was a baby with known early onset severe fetal growth restriction with poor prognosis; 1attended in labour – no FH on arrival, this has been referred to MNSI. 2 in October – 1 extreme pre-term SROM and 1 arrived for planned C section – no FH on arrival; 1 in November – Pre-term labour, rescue suture in situ, baby born with no signs of life. These are being reviewed by the PMRT process.

Term admission to NICU:
The Term admission rate has remained stable with a slight rise in September. All of these are reviewed by the ATAIN process. So far, none of the cases this year have been identified as potentially avoidable., but 4 are having further review at present.

3rd/4th degree perineal tears
The number of 3rd/4th degree tears had remained stable since February – however there was a significant increase in September and October – these have been reviewed and there are no apparent themes. The number has decreased in November although final percentage not yet available.. These will continue to be closely monitored.

Training Compliance:
The average for training compliance across all staff groups remains >90% attendance.

	Metric	Standard	August 25	September 25	October 25	November 25
Perinatal Data	1:1 care in labour	100%	100%	100%	100%	100%
	Stillbirth rate	<4.4/1000	3.72	3.7	4.0	2.2
	Term admissions to NICU	<7%	4.59%	5.67%	4.45%	4.0%
	Obstetric haemorrhage >1.5 litre (within 24hrs)	<10%	4.15%	4.38%	2.97%	Data N/A
	3rd/4th degree perineal tear	<5%	4.16%	7.09%	7.29%	Data N/A
Staffing/Training	Maternity NICE red flags		0			
	Dedicated obstetric consultant presence on labour ward	90hrs/week	90	90	90	90
	Midwife to birth ratio (establishment)	<1.28	<1.28	<1.28	<1.28	<1.28
	Midwife to birth ratio (in post)	<1.28	<1.28	<1.28	<1.28	<1.28
	Training compliance for all staff groups (CNST)	>90%	>90%	>90%	>90%	>90%

	Metric	Standard	August 25	September 25	October 25	November 25
Feedback	Service user feedback (MNVP)		1 session attended	1 session attended	0 session attended	1 session attended
	FFT satisfaction rated as good	>90%	94%	92.8%	89.9%	92.8%
	Number of level 4 complaints	-	2	4	1	2
	Executive safety walkaround	Bi-Monthly	2	0	1	1
	Maternity/ Neonatal Safety Champion walkaround	Bi-Monthly	0	1	1	0

MNVP Service User Feedback:
MNVP engagement lead attended an engagement event at Blackburn Birth centre. Feedback gathered has been added to the ELHT tracker.

FFT satisfaction rated as good:
There has been an increase in the number of FFT responses rating care as good apart from in October. There is an action plan in progress to address the themes identified from poor feedback.

Level 4 Complaints
There have been level 7 complaints in the last 3 months. These are monitored and any themes identified. These include experiences in care and communication.

Executive Safety Walkarounds: Executive walk rounds took place in Antenatal ward, triage and induction.

Maternity/ Neonatal Safety Champion walkaround: Took place in ANW and PNW. Feedback and actions have been shared with the team on PNW.

Moderate or above incidents:
eIR1319179 – extravasation injury during ferrinject infusion
eIR1324539 – concealed pregnancy and birth – Mum in ICU due to sepsis
eIr1324544 – 3rd degree tear – forceps without episiotomy
eIR1325877 – Csection wound infection – admitted for debridement of necrotic tissue
eIR1326400 – PPH resulting in hysterectomy post C section

Coroner referral:
0 cases have been referred to the Coroner in this period.

MNSI referral:
1 case was referred to MNSI in September – this was an intrapartum stillbirth as the mum attended in labour and no FH was detected.

CNST:
Reporting as full compliance with CNST. Monitoring period ended on 30th November..

	Metric	August 25	September 25	October 25	November 25
External Reporting	Maternity incidents graded moderate or above	1	1	2	2
	Cases referred to MNSI	1	2	0	0
	Cases referred to coroner	0	1	0	0
	Coroner reg 28 made directly to the Trust	0	0	0	0
	HSIB/CQC with a concern or request for action	0	0	0	0
CNST	Progress with CNST 10 safety action compliance	●	●	●	●

Formal staff feedback annual metrics	
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	86.56% (GMC survey 2023) National mean 81.8%

This data set is provided to the Board-level safety champions and reviewed at each bi-monthly Floor to Board meeting, alongside contextual information from the Maternity Performance Dashboard and Exceptions Reports, which highlight key themes and trends. The Maternity and Neonatal Voice Partnership (MNVP) lead attends these meetings and is invited to contribute relevant user feedback.

In addition to this bi-monthly assurance process, a comprehensive review triangulating claims, incidents, and complaints intelligence has been presented to the Floor to Board meetings in June 2025, October 2025, and December 2025. The most recent version of this review is provided in **Appendix 6.** Discussion and oversight are evidenced within the corresponding Floor to Board meeting minutes.

Themes and learning identified through PMRT reviews, MNSI investigations, and triangulation of incidents, claims, and complaints are reviewed through established governance routes and translated into quality improvement actions. Progress against these actions is monitored via the Perinatal Governance Board and escalated to the Floor to Board meetings as required. A five-year review of all PMRT cases and mortality has been completed by the neonatal safety champion and clinical director for neonatology and the obstetric PMRT consultant lead. The five-year review was presented at Quality committee in December 2025.

Maternity and neonatal culture improvement plan

The maternity and neonatal culture improvement plan continues to progress, culture coaches have continued with coaching sessions across all areas of maternity and neonatology throughout the CNST reporting year:

- 4th Feb 2025 – Central Birth Suite Leaders
- 26th March 2025 – Neonatal Medical Team
- 28th March 2025 & 27th June 2025 – Obstetrics Medical Team
- 1st May 2025 – Maternity Theatres
- 22nd May 2025 – Burnley Birth Centres
- 22nd May 2025 – Postnatal Ward
- 23rd May 2025 – Antenatal Clinic and Day Unit
- 3rd June 2025 – Close Observation Unit
- 27th August 2025 – Maternity Support Workers
- 3rd September 2025 – Blackburn Birth Centres
- 24th September 2025 – Central Birth Suite Midwives
- 10th October 2025 – Bereavement Midwives

There is a culture coaches' conversation for Antenatal Ward outstanding, which has needed to be re-arranged due to ward/ staffing pressures.

The feedback from these sessions has been reviewed by the coaches with support from the Perinatal Transformation Project Support Officer and key themes for each area, and themes across the whole unit, have been highlighted and discussed within perinatal quadrumvirate meetings. These discussions continue to take place, and the improvement plan is a live document which is constantly under development.

To communicate the progress with this plan effectively with staff, an engaging infographic format is being used. The themes which have been highlighted across all sessions are included on the infographic below which was shared via the Maternity and Neonatal Safety Champions Newsletter 10th Edition – appendix 7. This newsletter also gives information regarding feedback collected via walk rounds and response from the safety champions.

SCORE Survey
Feedback following Culture Coach sessions

East Lancashire Hospitals NHS Trust
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The Culture Coaches have been engaging with teams across Maternity and Neonatology to explore the SCORE survey results in greater depth. Their aim is to support the Maternity and Neonatal Quad in driving forward meaningful cultural improvements. Key themes have been identified across multiple areas, alongside a breakdown of specific themes within each individual area. Initial actions have been agreed, and progress will be reviewed and monitored through the monthly Quad meetings. Thank you to all staff who have contributed to these sessions, your insights are helping to create a more positive culture for everyone.
Culture Coach sessions are scheduled for 3rd September at Blackburn Birth Centre and 24th September on the Antenatal Ward. A session is also being planned for CBS midwives.

Area	Feedback Theme	SCORE Theme	Actions
Theme across multiple areas	Unmanageable workload	Burnout climate	• Community BGH - Roll out of 30 minute appointments, plus admin slot at the end of each day • Antenatal clinic - Review the current clinic templates / number of clinics against our demand • Theatres - Elective sections scheduling and running to be reviewed by transformation team manager.
Theme across multiple areas	No protected admin time	Work life balance & personal burnout	• Community BGH - Roll out of 30 minute appointments, plus admin slot at the end of each day • CBS leaders and COU - To be discussed at the next quad meeting
Theme across multiple areas	Slow & too many IT systems	Personal burnout	• All issues raised to the digital midwife / consultant lead are monitored through the Digital Operations group and any risks that meet criteria are raised at Floor to Board with the Maternity and Neonatal Board safety champions.
Theme across multiple areas	Concerns regarding escalation process	Safety climate	• Implementation of 'Each baby counts' escalation tool planned for October. • The new maternity triage SOP to include detailed escalation pathways
Theme across multiple areas	Lack of communication around decisions made / outcomes raised by staff	Local leadership	• Arrange safety champions walk rounds of all areas to discuss ongoing work relating to the feedback. • Regular updates included in the Maternity and Neonatal Safety Champions newsletter following discussion at quad meeting.
Theme across multiple areas	Staff constantly feeling burnt out / overwhelmed / frustrated	Burnout climate	• To be discussed at the next quad meeting
Theme across multiple areas	Lack of support from leadership	Local leadership	• Leaders to make themselves visible on the shop floor and promote an open door culture • The Recruitment and Retention Lead has developed a TNA and support pack to help midwives strengthen their leadership skills. Initially designed for Band 7/8s, the template will also support Band 5/6s preparing for future leadership roles.

Safe | Personal | Effective

3.2.10 Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations Special Health Authority (MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025?

The Perinatal Quality Surveillance Model – Minimum Data Set as above contains monthly data of the number of HSIB/MNSI cases reported and accepted or rejected.

A detailed overview of cases within the reporting period to present are provided in the quarterly reports produced by the Quality and Safety Lead. The quarter 3 report is submitted as per **appendix 8**

3. CONCLUSION

On behalf of ELHT maternity and neonatology services this bimonthly assurance report to ELHT trust board informs all progress with the evidence requirements for the ten CNST maternity safety actions throughout the year 7 reporting period.

Any other matters of concern relating to patient experience, safety and service delivery will continue to be reported through the bimonthly maternity and neonatology safety champions floor to board agendas for wider discussions with appropriate escalation. Progress and evidence in relation to the four themes and deliverables identified within the Maternity & Neonatology three-year delivery plan is reported through ELHT Quality committee bimonthly.

Perinatal Quadrumvirate:

Tracy Thompson, Divisional Director of Midwifery and Nursing
Martin Maher, Clinical Director - Obstetrics/Gynaecology
Rajasri Seethamraju, Clinical Director -Neonatology
Charlotte Aspden, Directorate Manager - Maternity and Neonatology
January 2026

Appendix 1 – November 2025 Maternity SPC Report
Appendix 2 – November 2025 Maternity SPC Exceptions Report
Appendix 3 – Quarterly MNVP Meeting Minutes
Appendix 4 – 2025 CQC survey action plan
Appendix 5 – December 2025 Floor to Board minutes
Appendix 6 – Triangulation Exercise
Appendix 7 – Maternity and Neonatal Safety Champions Newsletter 10th Edition
Appendix 8 - MNSI Q3 Report

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/013
Report Title:	Patient Safety Incident Response Assurance Report		
Author:	Lewis Wilkinson, Incident and Policy Manager Jacquetta Hardacre, Assistant Director of Patient Safety and Effectiveness		
Lead Director:	Mr J Hobbs, Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
				✓
Executive Summary:	The Trust Board is asked to receive the paper as a summary update on the incidents reported under the new Patient Safety Incident Response Plan (PSIRP) and the outcome of the Patient Safety Incidents Requiring Investigation (PSIRI) Panel decision-making process on high level investigation reports.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	None			

Previously Considered by:	Quality Committee
Date:	17 December 2025
Outcome:	Accepted – no actions

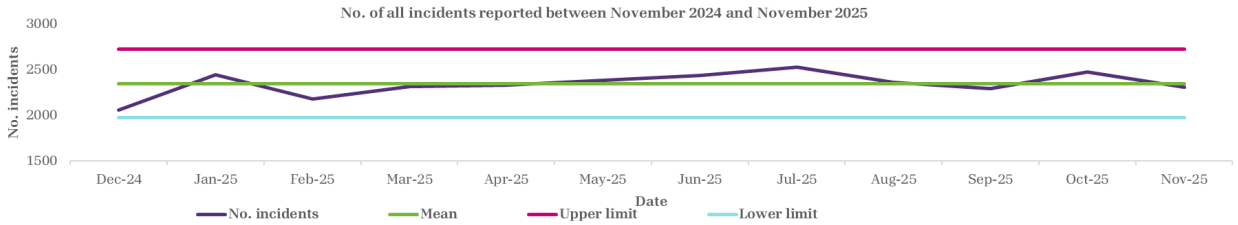
Patient Safety Incident Response Framework Report

Reporting period		October 2025 to November 2025
Date and name of meeting:		Information within this report forms part of the Patient Safety Incident monitoring dashboard and PSIRF which is discussed and reviewed at the bi-monthly Patient Safety Group and discussed at the Trust Wide Quality Governance Part B meeting in July 2025.
1a.	**Alert**	Incident and Policy Team have been working at reduced capacity since July 2025, and this is having an impact on the teams KPIs. Normal capacity is 4.4WTE team have been working at times with only 2WTE. • 1 vacancy since July 2025 still awaiting Trust approval to advertise • Incident and Policy Manager was on Jury service for 6 weeks during November and December 2025 • 1 member of team currently off long term sick. Two Never Events reported 1. A Never Event was declared to ICB on 24th October regarding Wrong Site Surgery (small polyp removed from wrong site inside left cheek) on 27th September 2025 in Oral & Maxillofacial Surgery (OMFS) outpatient clinic. The patient raised a concern though the complaints procedure and an incident raised. Patient has since had the correct polyp removed and diagnostic tests completed, and assurance provided to patient no issues identified from tests. Incident was discussed at a Round Table meeting on 24th October with staff involved. DOC has been completed and agreed copy of final report will be shared with patient. ICB and CQC informed. *(highlighted in previous Trust Board report)* 2. A Never Event was declared to ICB on 10th December regarding retained foreign object, swab identified as missing after closure of patient but before patient left theatre on 28th November. Count was completed prior to closure and all correct. Small Swab handed over to surgeon for dabbing and medium swab on the table. Swabs then handed out to other scrub nurse and small swab noticed to be missing when these were being put in the swab safe. Incident was discussed at a Round Table meeting on 4th December with staff involved. DOC has been completed and agreed copy of final report to be shared with patient. ICB and CQC informed.
1b.	**Advise**	There have been 2 breaches of the Trusts Duty of Candour Policy. Duty of Candour monitoring has now been included in the weekly Complex Case meetings for escalation and action.
1c.	**Assure**	NHS England Northwest and published a SOP for the management of Patient Safety Incidents. The document seeks to support NHS England Northwest Region, ICBs and providers to ensure robust systems are in place for reporting, investigating and responding to Patient Safety Incidents. Currently all incidents meeting the criteria within ELHT are StEIS reported to the ICB. StEIS is due to be switched off in the coming months. The Trust DATIX system also automatically reports into the national LfPSE database as required and the ICB have access to all Patient Safety incidents reported on this platform. • It has been agreed between the Trust and ICB that once StEIS is no longer in use the Trust will inform them of any incidents meeting the PSIRF guidance by email directly to them. The ICB attend the Trusts PSIRI panel where all incident investigations meeting the criteria are reviewed and approved with any learning. No further action against the SOP is required by the Trust

Incident Reporting

1.1 The Trust reports and manages incidents in line with the New National Patient Safety Incident Response Framework. Over the last year, there continues to be expected variation in the number of incidents reported per month. However, reporting levels remain with control limits, this is common cause variation which we would expect with the nature of incident occurrence and reporting.

Figure 1: Incidents reported over last 12 months.



1.2 **4761** reported incidents were triaged within 2 working days of being reported in **October and November 2025**, which equates to 99.7**%** of all incidents reported within this period.

1.3 At the end of **November 2025** there were **3175** incidents awaiting final approval. Of these **416** cannot be finally approved due to open S42 incidents awaiting Local Authority outcome, incidents awaiting information from Divisions, and outstanding Infection Control reviews included within cluster reviews. This left **2759** incidents awaiting final approval that could potentially be closed.

1.3.1 There has been a significant increase in the number of incidents awaiting final approval due to staffing capacity within the Incident & Policy Team which includes 1 vacancy since July 2025 still awaiting Trust approval to advertise, 1 member of staff on Jury service for 6 weeks and another on long term sickness.

1.4 The proportion of moderate physical harms remains in line with the average number reported in 2024/25 (1.42%), however is significantly under the proportion of moderate harms that are reported nationally. This may be indicative of a misapplication of the harm guidance and so incidents are graded with the incorrect harm. However, it should also be noted that currently the national data is unvalidated with many trusts reporting data quality issues. (appendix A)

1.5 The proportion of reported severe harms has increased slightly in November 2025 and is in line with the average level reported by the Trust in 2024/25.

1.6 Four fatal incidents were reported in November 2025 which is in line with the average from 2024/25 but remains significantly under national levels.

1.7 A total of nine fatal incidents were reported in October and November 2025:

1.7.1 eIR1324478 related to aspiration pneumonia and whether this was related ice cream given against SLT recommendations.

1.7.2 eIR1326282 a potential missed case of appendicitis.

1.7.3 eIR1323553 was initially reported as Fatal, however on review it has been changed to no harm.

1.7.4 eIR1323954 relates to a death following a fall.

1.7.5 eIR1324280 was initially reported as Fatal, however on review it has been downgrade to no harm.

1.7.6 eIR1326893 & eIR1326901 are for the same patient patient and relate to a death with potential issues around discharge and follow up on referrals.

1.7.7 eIR1325726 was initially reported as Fatal, however on review it has been downgrade to no harm.

1.7.8 eIR1326776 relates to potential issue with management of enoxaparin dosage and a subsequent bleed.

1.8 A Never Event was declared to ICB on 10th December regarding a retained foreign object, a swab was identified as missing after closure of patient but before patient left theatre on 28th November. A count was completed prior to closure and all correct. A small swab was handed over to surgeon for dabbing and a medium swab was on the table. The swab was then handed out to another scrub nurse and a small swab was noticed to be missing when these were being put in the swab safe.

1.8.1 Incident was discussed at a Round Table meeting on 4th December with the staff involved. DoC has been completed and agreed a copy of the final report to be shared with patient. The ICB and CQC have been informed.

2. Duty of Candour

2.1 There have been 2 breaches, of the Trusts Duty of Candour Policy. Duty of Candour monitoring has now been included in the weekly Complex Case meetings for escalation and action.

3. Safety Incident Responses (IR2s)

3.1 In line with the New Patient Safety Incident Response Framework all incidents not being investigated as a Patient Safety Response, or a Patient Safety Incident Investigation the Trust has set a target that these should be reviewed and actioned

within 30 days of reporting. A KPI of 90% has been set and appendix B provides an overview by division.

3.2 Overall, the number of IR2s completed within 30 calendar days by handlers within the divisions has generally improved over the year but there has been a slight decrease reported at the end of October. The number of IR2s open more the 30 calendar days has also slightly increased. These will continue to be monitored monthly.

4. Patient Safety Responses (PSR)

4.1 All incidents that are of moderate or above harm and/or have key safety issues identified, and do not meet the national or local reporting priorities for a PSII are required to have a Patient Safety Response (PSR) completed and are managed within Division. Appendix C provides a breakdown of the number of open PSRs by division and number of any open more than 3 months.

4.2 Overall, there has been an improvement in the number of open PSRs completed by the divisions and the number of those that have been open more than 90 calendar days.

5. Patient Safety Incident Investigations (PSII) National and Local Priorities

5.1 In **October and November 2025**, the Complex Case meeting reviewed **11** new incidents and reported **8** incidents that met the PSIRF Priorities and required either a PSII or MNSI investigation, the PSIIs have been allocated to lead investigators within the Patient Safety Team.

5.2 A KPI dashboard of PSIIs is provided is appendix D. At the end of **November 2025**, the Trust had **18** open PSII incidents of which **7** were being investigated by MNSI.

5.3 At the end of **November 2025** there was **1** PSII which had been open longer than 6 months and **2** MNSI reports. Two of the MNSI reports have been received by Family Care Division and are being reviewed for accuracy before presenting at PSIRI.

5.4 In **October** and **November 2025**, **8** PSII reports were approved by PSIRI with learning and closed of which **4** where MNSI reports.

6 PSIRI Panel Approval and Learning from Reports

6.1 During **October** and **November 2025, 5** reports were reviewed, of these there were **3** were new PSII reports. See appendix E for the detail of these reports and the review outcome.

7 Mandatory National Patient Safety Syllabus Training Modules

7.1 At the end of **November 2025**, the Trust achieved **97%** Level 1a, **92%** Level 1b and **96%** Level 2 for National Patient Safety Training. There is a National recommendation that all NHS staff should complete at least Level 1a Patient Safety Training, the Trust took the decision to include level 1b and level 2 as well for appropriate clinical staff and senior managers and set a KPI target of 95% for all 3 levels.

7.2 Table 1: Patient Safety Syllabus Training (as of end of **November 2025**)

National Patient Safety Training	Target	Dec24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Level 1a	95%	95.20%	95.40%	95.60%	95.80%	96.20%	Unable to obtain	96.00%	96.00%	98.00%	97.00%	97%	97%
Level 1b		86.00%	87.30%	87.90%	89.60%	90.00%	Unable to obtain	91.00%	92.00%	94.00%	92.00%	92%	92%
Level 2		92.10%	92.70%	92.90%	93.30%	93.60%	Unable to obtain	95.00%	94.00%	96.00%	96.00%	96%	96%

8 Trust Wide Policies and SOPs

8.1 At the end of **November 2025**, there were **16 (88%)** Trust wide SOPs out of **156** overdue their review date, and **31 (91%)** out of **307** policies overdue their review date.

8.2 The report provides a breakdown of overdue policies and SOPs as requested by Trust Board and a full list is provided in appendix F.

8.3 Pharmacy and HR have the highest number of policies and SOPs overdue; however, this had reduced and both areas continue to work to reduce the number further.

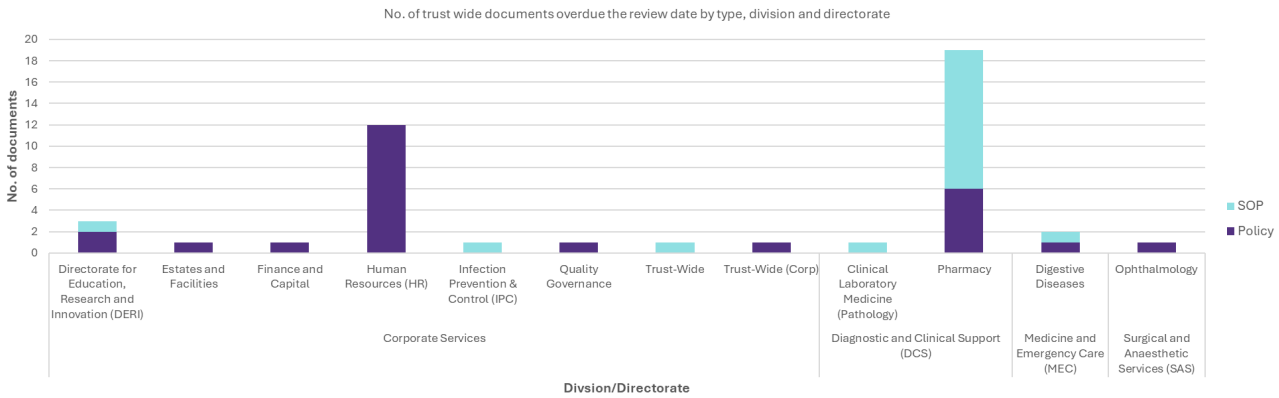


Table 2: Trust wide polices and SOPs within review date:

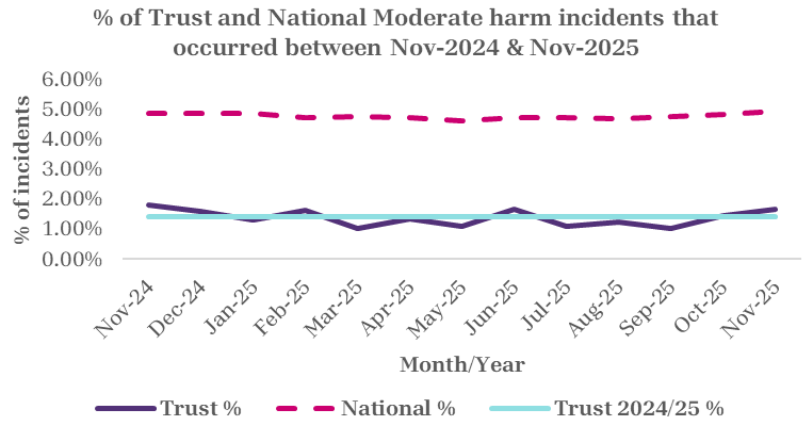
Policies / SOPs	Target	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Trend
Trust wide Policies	90%	95.58%	94.28%	94.30%	90.91%	88.14%	86.96%	91.69%	91.03%	90.40%	91.86%	92.00%	91.56%	
Trust wide SOPs		97.92%	94.44%	90.21%	88.03%	85.14%	86.18%	92.21%	96.75%	96.13%	88.96%	89.00%	88.54%	

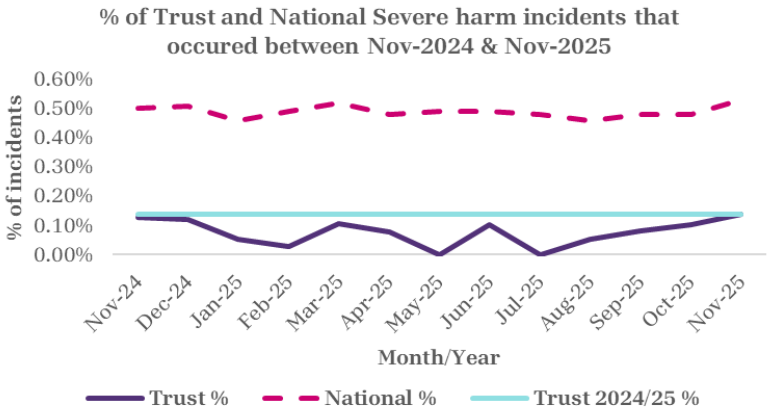
9 Maternity specific serious incident reporting in line with Ockenden recommendations

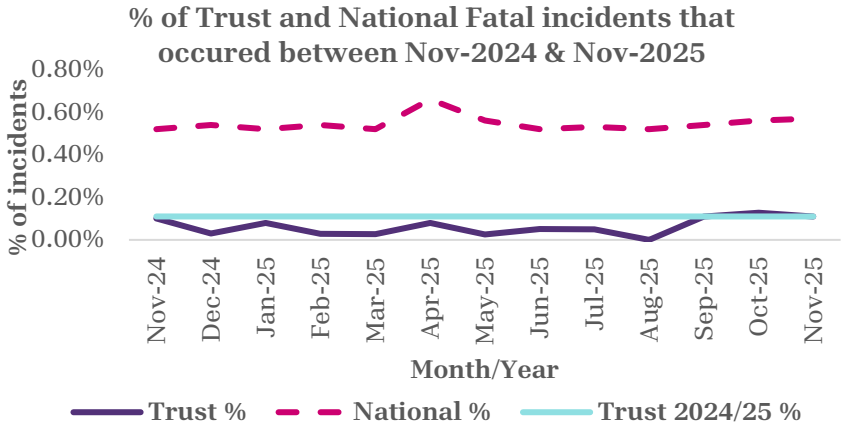
9.1 Following recommendations from the Ockenden review, the Trust is required to report on the number of Maternity specific serious incidents reported on StEIS and the status of the open investigations. Since March 2020 **84** maternity related incidents have been reported on StEIS of which:

- **56** have been approved and closed
- **15** have been agreed for de-escalation from StEIS
- **5** have had closure on StEIS requested
- **7** are currently being investigated by MNSI
- **1** is currently under investigation by the Trust.

Appendix A: ELHT Incidents by Moderate harm and above







Appendix B: KPI Dashboard for IR2s

Division	Number of SIRs (IR2s) by Month Trust Target 90%	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Trend
CIC	Total IR2 reported	405	405	524	423	403	484	462	417	494	455	416	434	
	(total number investigated) % complete within 30 calendar days	(373) 92.10%	(356) 87.90%	(479) 91.41%	(387) 91.49%	(362) 89.83%	(458) 94.63%	(423) 91.56%	(386) 92.57%	(446) 90.28%	(424) 93.19%	(382) 91.83%	(374) 86.18%	
DCS	Total IR2 reported	189	118	103	97	100	91	110	120	120	153	117	129	
	(total number investigated) % complete within 30 calendar days	(154) 81.48%	(85) 72.03%	(69) 66.99%	(61) 62.89%	(78) 78.00%	(71) 78.02%	(85) 77.27%	(103) 85.83%	(83) 69.17%	(118) 77.12%	(85) 72.65%	(97) 75.19%	
FC	Total IR2 reported	268	210	245	259	227	245	254	332	259	290	281	301	
	(total number investigated) % complete within 30 calendar days	(224) 83.58%	(187) 89.05%	(224) 91.43%	(212) 81.85%	(177) 77.97%	(212) 86.53%	(211) 83.07%	(283) 85.24%	(242) 93.44%	(254) 87.59%	(232) 82.56%	(226) 75.08%	
MEC	Total IR2 reported	921	778	908	815	962	903	956	930	1012	875	889	970	
	(total number investigated) % complete within 30 calendar days	(707) 76.76%	(495) 63.62%	(730) 80.40%	(630) 77.30%	(752) 78.17%	(679) 75.19%	(751) 78.56%	(725) 77.96%	(803) 79.35%	(652) 74.51%	(660) 74.24%	(660) 70.72%	
SAS	Total IR2 reported	357	326	372	314	377	344	335	343	372	357	375	376	
	(total number investigated) % complete within 30 calendar days	(310) 86.83%	(248) 76.07%	(313) 84.14%	(253) 80.57%	(282) 74.80%	(260) 75.58%	(286) 85.37%	(281) 81.92%	(316) 84.95%	(290) 81.23%	(295) 78.67%	(291) 77.39%	
Corp	Total IR2 reported	76	32	66	43	39	42	52	46	71	45	55	52	
	(total number investigated) % complete within 30 calendar days	(22) 28.95%	(20) 62.50%	(41) 62.12%	(24) 55.81%	(18) 46.15%	(20) 47.62%	(28) 53.85%	(24) 52.17%	(46) 64.79%	(27) 60.00%	(30) 54.55%	(27) 51.92%	
Trust Total	Total IR2 reported	**2216**	**1869**	**2218**	**1951**	**2108**	**2109**	**2169**	**2188**	**2328**	2175	2133	2262	
	(total number investigated) % complete within 30 calendar days	**(1790) 80.78%**	**(1391) 74.72%**	**(1856) 83.68%**	**(1567) 80.32%**	**(1669) 79.17%**	**(1700) 80.61%**	**(1784) 82.25%**	**(1802) 82.36%**	**(1936) 83.16%**	**(1765) 81.15%**	**(1684) 78.95%**	**(1701) 75.20%**	

Appendix C: KPI Dashboards for PSRs

Division	Number of PSRs open	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Trend >90
CIC	No. open	83	52	49	38	38	34	50	70	56	53	52	30	
	No. open more than 90 calendar days	5	2	4	2	2	3	1	0	4	2	2	0	
DCS	No. open	9	9	10	6	6	7	9	9	12	7	8	4	
	No. open more than 90 calendar days	0	0	0	1	1	1	2	2	2	1	2	1	
FC	No. open	38	45	44	19	53	48	37	54	44	39	19	9	
	No. open more than 90 calendar days	5	5	3	2	3	6	6	11	8	6	8	3	
MEC	No. open	71	82	80	66	73	71	88	76	87	92	112	102	
	No. open more than 90 calendar days	9	15	19	15	15	12	16	14	18	25	32	19	
SAS	No. open	28	48	34	27	17	14	31	36	79	38	47	26	
	No. open more than 90 calendar days	7	7	7	6	6	2	1	2	2	4	6	3	
Trust	No. open	**232**	**236**	**217**	**188**	**187**	**174**	**215**	**245**	**278**	**229**	**238**	**174**	
	No. open more than 90 calendar days	**26**	**29**	**33**	**26**	**27**	**24**	**26**	**29**	**34**	**38**	**50**	**26**	

Appendix D: KPI Dashboards for PSIIs

PSII reports (including HSIB/PMRT)	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Trend
No. new incidents at Complex case	3	2	5	3	0	1	3	4	1	2	3	8	
No. incidents agreed as PSII including (MNSI)	4	2	5	3	0	1	2	4	3	3	6	2	
Total No. of PSIIs Open including (MNSI)	24(8)	23(9)	27(9)	27(12)	22(10)	20(10)	19(9)	17(8)	20(9)	18(7)	21(8)	23(8)	↑
No. over 6 months	11(4)	8(4)	10(4)	7(4)	6(4)	6(5)	0(1)	1(0)	0(3)	0(4)	0(1)	3(2)	↑
No. approved/closed by PSIRI including (MNSI)	3	3	2	2	5	2	2	6(1)	0	5(2)	3(2)	1	

Appendix E: Summary of PSII reports reviewed by PSIRI and the outcome

During **October and November 2025 3** new PSII reports were presented at the Trusts PSIRI panel**.**

- eIR1316159 - The report was approved with a minor amendment to include the family decision not to be involved in the investigation. The investigation did not identify any aspects of care that impacted on the outcome for the patient. There was some incidental learning identified relating to documentation and the implementation, monitoring and completion of the nurse handover document but this did not contribute to the patient's death.

- eIR1303038 – This investigation was undertaken by MNSI, the report was approved. MNSI did not identify any safety recommendations.

- eIR1303342 - The report was approved with some additional information to be added to the improvement plan and to be resubmitted. The safety recommendations identified improvements by ensuring the most currently silver trauma screening pathway is communication and any outdated documents removed, mandating electronic documentation of decisions to redirect patients from resus, and reviewing the step-down SOP to incorporate safeguards requiring a senior UIT clinician to perform a primary survey if a resus clinician has not assessed the patient. Additionally measures to introduced to add a safety net field to the initial assessment form to flag deflected or stepped down patients, increasing character limits in electronic records, and updating Emergency Department smart templates to automatically include Early Warning Scores alongside clinical observations.

Appendix F: Overdue Trust wide Policies/SOPs

Division/Directorate	Ref	Title	Review Date
Corporate Services			
Directorate for Education, Research and Innovation (DERI)	C182	Advanced Clinical Practitioner (ACP) Verification of Adult In-patient Death following cessation of Cardiorespiratory function	28/11/2025
	C184	Advanced Clinical Practice Role Equivalence & recognition of competence &capability	30/09/2025
	SOP065	Safe collection of Peripheral Vein Blood Culture (Adults & paediatrics, not neonates)	30/09/2025
Estates and Facilities	C158	Electrical Safety Policy	28/11/2025
Finance and Capital	F20	Welsh, Scottish & Northern Ireland Office Patients Procedure Notes	30/09/2025
Human Resources (HR)	C086	Assistance Dog Policy	31/07/2025
	C099	Clinical Attachment Policy	31/03/2025
	HR11	Supporting Staff with Disabilities Policy	28/02/2025
	HR15	Facilities and Time Off for Recognised Representatives of Trade Unions and Staff Organisations	30/05/2025
	HR31	Alcohol, Drugs and Substance Misuse	30/08/2024
	HR43	Managing Organisational Change Policy & Procedure	30/05/2025
	HR51	Guidelines for Consultant Job Planning	31/03/2025
	HR52	Acting Down Policy - Guidelines on Senior Staff covering Junior Doctor Rotas	28/11/2025
	HR58	Policy on the Development of Professional Roles	31/12/2024
	HR65	Compensatory Rest for Doctors (non resident on call)	30/04/2025
	HR68	Undertaking Private Practice	30/04/2025
	HR80	Agile Working Policy	31/10/2025
Infection Prevention & Control (IPC)	SOP008	Use insertion care maintenance and removal of a Peripheral Intravenous cannula	30/09/2025
Quality Governance	C157	Chaperones Accompanying Patients During an Intimate Procedure / Treatment	30/04/2024
Trust Wide (Corporate)	C116	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Adult Policy (Unified)	31/10/2025
	SOP085	Risk Stratifying Process for Follow Up Patients	30/04/2025

Division/Directorate	Ref	Title	Review Date
Diagnostic and Clinical Support			
Clinical Laboratory Medicine (Pathology)	SOP015	Administering Injectable Medicines	31/03/2025
Pharmacy	C064	Medicines Management	30/09/2025
	MM01	Guidelines for the Prescribing, Supply and Use of Unlicensed Medicines	31/03/2025
	MM02	Policy for Supply and / or Administration Of Prescription Only Medicines Under Patient Group Directive	31/12/2024
	MM03	Medicines Reconciliation Policy	30/05/2025
	MM06	Prescribing for Clinical Need Policy	30/09/2025
	MM08	Medicines Management for Midwives Policy	28/11/2025
	SOP014	Preparing Injectable Medicines	31/03/2025
	SOP032	Ordering of Controlled Drugs for Ward Stock	28/11/2025
	SOP044	Dealing with suspected Drug Misuse by Staff	30/09/2025
	SOP046	Exceptional Medicines that may be stored in Controlled Drug cabinet	30/09/2025
	SOP047	Procedure for the Ordering of Epidural Infusions by Wards and Departments	28/11/2025
	SOP048	Receipt, storage, transfer of medicines and cold chain medicines on Wards and Departments	30/09/2025
	SOP051	Short stay medicines discharge procedure	30/09/2025
	SOP053	Handover of medicines to patients-carers at hospital discharge	30/09/2025
	SOP055	Pharmacist supply of Nicotine Replacement Therapy for inpatients in hospital by Pharmacists	30/09/2025
	SOP057	Delayed and omitted doses of medicines procedure	30/09/2025
	SOP060	Procedure for supply of medicines in Monitored Dose Systems	30/09/2025
	SOP090	Management of Unlicensed Medicines in Clinical Areas	28/11/2025
	SOP113	Procedure for the Management of Oxygen During Periods of High Demand	30/09/2025
Medicine and Emergency Care (MEC)			
Digestive Diseases	CP19	Protocol for the Supply and Administration of Oral Bowel Cleansing Preparation (BCP) prior to Colonoscopy	30/09/2025
	SOP149	Endoscopy to Ward Handovers at ELHT	31/10/2025
Surgical and Anaesthetic Services (SAS)			
Ophthalmology	C059	Laser Safety Policy	28/11/2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

BOARD OF DIRECTORS REPORT

Meeting Date:	14th January 2026	**Agenda Item:**	TB/2026/015
Report Title:	Board Assurance Framework		
Author:	Executive Team		
Lead Director:	Susan Giles Interim Director of Corporate Governance		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
	✓			
Executive Summary:	The risks on the BAF have been reviewed by the relevant Board Committees. The risk scores have been reviewed and remain unaltered. Actions have been updated. For ease of reference updates appear in blue font. The BAF is scheduled for a full refresh at the April Board strategy session. This will provide the opportunity for the Board to review its risk appetite statement, to align the BAF to the refreshed Trust Strategy and to consider the new format for the BAF, which has been approved by the Audit Committee.			
Key Issues/Areas of Concern:				
Action Required by the Committee:	The Board is asked to consider whether they are assured that: • Controls are effectively managing the level of risk? • Actions are on track for delivery and will effectively mitigate the risk to an acceptable level?			

Previously Considered by:	
Date:	
Outcome:	

BAF Risk 1 – Integrated Care / Partnerships / System Working

Risk Description: The strategies and partnership arrangements across the Integrated Care System (ICS) do not deliver the anticipated benefits for our communities and fail to support the financial recovery of the Trust, including exit from NHS Oversight Framework Segment 4 (Recovery Support Programme)

Executive Director Lead: Chief Executive / Executive Director of Service Development and Improvement

Strategy: ELHT Strategic framework (Partnership Working)

Links to Key Delivery Programmes: Care Closer to Home/Place-based Partnerships, Provider Collaborative, Tackling health and care inequalities

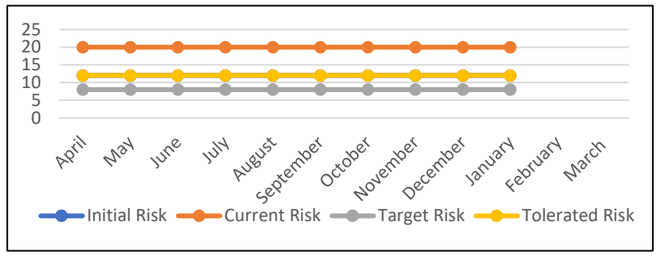
Date of last review: December 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR): Currently there are no risks on the CRR that are rated at 15 and above that are related to BAF risk 1.

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating:	**C5 x L4 = 20**
Initial Risk Rating:	C4 x L3 = 12
Tolerated Risk	C4 x L3 = 12
Target Risk Rating:	C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Pursue/High/15-20

Controls in place to mitigate the risk:

Lancashire and South Cumbria Integrated Care System/Board (ICS/ICB):

- The ICB has worked with partners to develop a Joint Forward Plan and to create a clinical strategy blueprint. System clinical reconfiguration leadership support has been commissioned to drive forward the system transformation programme.
- The ICB has formalised commissioning intentions for 2025/26 alongside a commissioning delivery plan.
- The system PMO continues to develop to support delivery and monitoring of benefits realisation of system-wide programmes.
- ELHT has strong representation at all levels of system working and oversight groups to ensure alignment of plans.
- The ICB are developing an improvement plan as part of the Recovery Support Programme to support exit from NHS Oversight Framework Segment 4 (NOF4)

Provider Collaborative Board (PCB):

- The PCB drives key programmes of Clinical Services and Central Service redesign
- A Joint Committee has been formed to enable effective decision making for specified Programmes.
- ELHT plays a key role in the PCB including Chief Executive and Chair at PCB Provider Collaborative Board, lead Director Senior Responsible Officer (SRO) roles, representation at all other professional working groups.
- The Clinical Services Programme Board, oversees a programme of work focussed on clinical services configuration including fragile services.
- The Central Services Executive Committee oversees the delivery of One LSC including the transformation of the services and associated potential savings and other benefits of Central Services programmes with ELHT acting as the host of One LSC (refer to separate BAF risk 6).
- 3 of 5 Providers in the PCB are part of the Recovery Support Programme and as such, PCB plans will need to support the requirements of the Recovery Support Programme to support collective exit from NOF4.

Place-Based Partnership (PBP):

- Blackburn with Darwen Place and Lancashire Place are now agreed with place based delivery structures continuing to develop and be reflected in system commissioning intentions.
- Place + key forums in place to support delivery where needed across East Lancashire and Blackburn with Darwen e.g. Urgent and Emergency Care Delivery Board and delivery programmes being developed to align to NOF4.

ELHT:

- ELHT Strategic framework has been developed to ensure clear alignment of organisational aims to wider system aims.
- 10 Key Delivery and Improvement Programmes and associated improvement priorities have been agreed for 2025/26, alongside 8 key improvement priorities with key measures of success outlined. These will support the delivery of the Trust's Improvement Plan
- Dedicated Recovery Programme and PMO in place to support financial recovery.
- Revised Accountability Framework and Performance Improvement and Oversight Framework approved by the Trust Board in September

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- ICS/PCB/PBP Updates are a standing agenda item at Executive meeting and Senior Leadership Group.
- PCB Programme Update reports to the PCB Joint Committee.
- Weekly monitoring of Key Delivery and Improvement Programmes via Executive Improvement Wall
- Trust Improvement Register monitored at Divisional Transformation Boards and Clinical Effectiveness Committees.
- Organisational plans for operational planning established and agreed via Trust and System planning processes.
- Quarterly Performance and Improvement Meetings or other interventions/support agreed with specific teams
- Written PCB JC updates to the Board.

Specialist support, policy and procedure setting, oversight responsibility:

- Standing agenda item at Trust Board for updates on system working/PCB.
- System delivery plans are reflected in updates on Trust Key Delivery and Improvement Programmes.

Independent challenge on levels of assurance, risk and control:

- PCB Business Plan signed off by all partners. Ongoing assurance on delivery provided via PCB Board and oversight groups.
- Trust, PBP, PCB plans feed into ICS-level plans as part of the national operational planning processes and are scrutinised by NHS England.
- Mersey Internal Audit Agency (MIAA) audit of financial sustainability and improvement practice complete with action plan agreed and sign off at Audit Committee with substantial assurance
- MIAA audit of ELHT Business Planning processes complete with action plan agreed and sign off at Audit Committee with substantial assurance

BAF Risk 1 – Integrated Care / Partnerships / System Working

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Commissioning intentions need to support delivery of tangible improvements and system transformation and financial recovery.	Work with system partners to agree commissioning intentions for 2025/26 and ensure clear plans in place to achieve system transformation and financial recovery	Director of Service Development and Improvement with SRO leads	March 2026	Discussions with commissioners underway on commissioning intentions for 2026/27 to inform the Trust's Annual plan submission for 26/27.	G
2.	System transformation programmes need to deliver significant system transformation to deliver quality and financial benefits and algin to the Recovery Support Programme (RSP)	Work with partners to develop and implement system transformation programmes via the Clinical Transformation Board.	Executive leads	March 2026	System clinical reconfiguration leadership support commissioned and agreed as part of the Recovery Support programme. Work underway to: • undertake a rapid diagnostic of current clinical transformation and reconfiguration plans. • Identification of programmes where transformation can be accelerated • Develop a clinical reconfiguration proposal Initial review of current programmes underway and additional information requests submitted to support system review. Next steps to be determined by the PCB/ICB. Meanwhile progress on reconfiguration of Pathology and Vascular services is underway. Due diligence for pathology is underway, updates through December Committees and January Board. Final approval at March Board meetings.	A
3.	Benefits for community services/out of hospital priorities not yet fully realised.	Work with Place + partners to further develop community services in line with the Community Transformation Programme to maximise benefits to support patients to receive care in their own home where possible and reduce demand in the acute setting.	Executive Director of Integrated Care, Partnerships and Resilience	April 2026	Co-production and co-delivery with place partners of service development and transformation including end to end pathway improvement across primary, community and acute settings. Agreement of clear targets and plans to reduce demand in secondary care, support increase care at home and support delivery of agreed Waste reduction Plan across the UEC pathway. Work underway to map the impact of changes to Primary Care Local Enhanced Services for impact on demand management to the hospital and to clarify opportunities from the system-wide review of Community Services as part of the Kingsgate Review. Blackburn with Darwen identified as Neighbourhood Health model/INT Pathfinder. L&SC successful in being identified as part of the National Frailty Programme.	A
4.	Embed the Trust Programme Management Office (PMO) with clear links between Trust key Delivery and Improvement Programmes/Priorities to support financial recovery	Establish PMO and strengthen key delivery and improvement programmes to support realisation of benefits (Delivery, Quality, Cost, People) and delivery of requirements to support exit from NOF 4.	Director of Service Development and Improvement, Director of Finance	April 2026	Some resourcing gaps identified and working with RSP to find additional personnel in the PMO team. The PMO continues to mature in terms of reporting, establishment of cross-cutting workstreams and development of mitigation plans and plans for 2026/27. Improvement Hub team and PMO working closely to ensure alignments of programmes and delivery of strengthening of reporting linked to delivery of WRP. Cross-cutting workstreams agreed and in the process of being implemented. Delivery of cross-cutting workstreams monitored at FIG.	G
5	Trust planning process will continue to mature to support floor to board connections of goals and priorities alongside wider system alignment (2026/27)	Refine and develop planning processes for 2026/27 linked to new NHS Plan, national planning guidance, NOF4 exit criteria and aligned to PCB/ICB processes supporting the creation of a new Trust Strategy and supporting plans from 2026/27	Director of Service Development and Improvement	April 2026	Following the system planning event on 20th June 2025 a full development and improvement plan has been agreed. Planning co-ordination group established, timetable for 2026/27 outlined and work now underway to take forwards. 1st draft submissions to NHSE made on 18th December. The Trust is now working to the February submission with an update to the January Board.	G
6.	Ongoing development of SPE+ improvement Practice to support delivery of key improvement priorities and to build improvement capability across the organisation/system	Ongoing review and development of SPE+ Improvement Practice at organisational and system level to build capability and support delivery and refresh of SPE+ Practice Plan/Strategy in line with NHS Impact	Director of Service Development and Improvement	March 2026	Improvement hub team capacity identified to support key improvement priorities for 2025/26, increased monitoring in place to support realisation of benefits aligned to Trust Waste Reduction Programme. Continue to review the offer from NHS Impact to align organisational and national improvement priorities. Work underway to ensure alignment of Improvement Hub Team to PMO with actions on track to support alignment and sharing of skills and alignment of working and reporting. H2 priorities for the Improvement Hub team agreed.	A
7.	Trust Accountability Framework can mature further to support and assure delivery of Trust priorities and realisation of benefits.	Implement and embed the revised Accountability Framework	Director of Service Development and Improvement	March 2026	Work ongoing to revise Quarterly Performance meetings, key measures and reporting aligned to the new framework. Meeting held on 7th January to agree the balanced scorecard. To be presented to January Senior Leadership Group with Qtr 3 meetings scheduled for end of February and Qtr 4 in May. MIAA review of Accountability Framework due to commence in February.	A

BAF Risk 2 – Quality and Safety

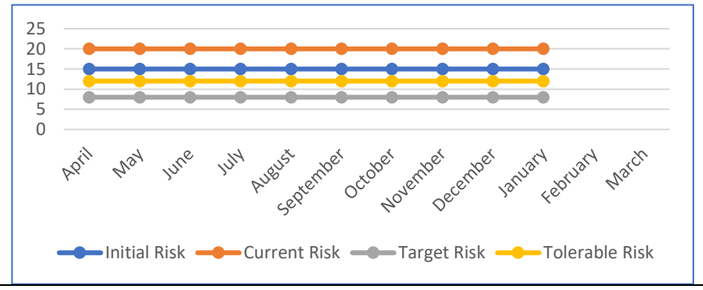
Risk Description: The Trust is unable to fully deliver on safe, personal and effective care in line with legislative and regulatory requirements.		**Executive Director Lead:** Executive Medical Director and Chief Nurse	
Strategy: Quality Strategy	**Links to Key Delivery Programmes:** Quality and Safety Improvement Priorities	**Date of last review:** Executive Review: December 2025	**Lead Committee:** Quality Committee

Links to Corporate Risk Register:

Risk ID	Risk Descriptor	Risk Rating	Direction of Travel
10086	Lack of adequate online storage for images	**20**	⟺
10065	Pharmacy Technical Service refurbishment programme	**20**	⟺
9755	Delays undertaking elective caesarean sections	**20**	⟺
9336	Increased demand with a lack of capacity within ED can lead to extreme pressure and delays to patient care	**16**	⇩
8941	Increased reporting times in histology due to increased activity outstripping resource	**20**	⟺
10062	Risk of harm and poor experience for patients with mental health concerns	**16**	⟺
9777	Loss of education, research and innovation accommodation and facilities	**16**	⟺
8061	Patients experiencing delays past their intended clinical review date may experience deterioration	**16**	⟺
~~**8033**~~	~~Increased requirement for nutrition and hydration intervention in patients resulting in delays~~	~~**16**~~	⟺
9900	Poor identification, management and prevention of delirium	**15**	⟺
8808	Breaches to fire stopping and compartmentalisation in walls and fire door surrounds – Burnley General Teaching Hospital.	**15**	⟺
~~**4932**~~	~~Patients lacking capacity to consent to hospital placements may be being unlawfully detained~~	~~**15**~~	⟺

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L4 = 20
Initial Risk Rating: C5 x L3 = 15
Tolerated Risk C4 x L3 = 12
Target Risk Rating: C4 x L2 = 8



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/2-6

Controls in place to mitigate the risk:

Strategy and Planning:

- Quality Strategy in place and delivery monitored by Quality Committee.
- Patient Experience Strategy in place.
- Progress against the 2025/26 priorities is reviewed by the Executive team via the Executive Improvement Wall.
- The current local priorities of the Patient Safety Incident Response Framework extended until September 2025. New local priorities to be agreed from October 2025.

Floor to Board Reporting and escalation (Risk and Quality):

- The established quality assurance process provides the golden thread enabling reporting and escalation between the Divisions and the Board.
- Board and Board Committees receive reports on risk/quality as part of their annual workplan.
- All Divisions have Quality and Safety meetings which coordinate Directorate assurance reports and escalation to the Quality Committee via the Trust Wide Quality Governance Group.
- Statutory requirements are monitored through the Quality Committee sub-groups structure.
- The Professional Standards Group and Employee Relations Case Review Group monitor professional/staff behaviours and all referrals to professional bodies.
- The Risk Assurance Meeting coordinates and monitors all risks reported as potentially scoring 15 or above and escalates to the Executive Risk Assurance Group (ERAG) before inclusion onto the Corporate Risk Register.
- Extreme Escalation Policy in place. Every morning at 8am, there is exec lead clinical safety meeting with A&E, divisions and flow team to manage and monitor patient admissions and flow.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Monitoring against Model Hospital, Getting it Right First Time (GIRFT), National Institute for Health and Care Excellence (NICE) guidelines, Internal and Clinical Audits (local and national), specialist commissioning, CQC insight data (monthly)
- Quality Walkrounds including Executive and Non-Executives.
- Establishment of 3s visits to all areas of the Trust, to listen to both staff and patients/carers, receive feedback and take action.
- Nursing Assessment Performance Framework (NAPF) Process has been reviewed and updated with ongoing reports to Quality Committee..
- Safe, Personal, Effective Care (SPEC) process in place with Board approved ratings of green/silver/gold wards/areas.
- Direct patient referrals into Same Day Emergency Care (SDEC) pathways to help bypass urgent care and ED.
- Acute medical physician in-reach into A&E from 8.00am – 12.00 noon and 4.00pm – 8.00pm
- Medical Examiners review the care provided to patients who have died in the Trust and can make recommendations or seek further action dependent upon their findings.
- Complex Case meeting weekly to monitor and allocate for investigation any patient/staff safety incidents identified.
- Monthly complaints and inquest drop-in sessions with each division to monitor performance and highlight risk
- Mobilisation of 24/7 IHSS service complementing the 24/7 Intermediate Care Allocation Team (ICAT) service Monday to Friday between 8am – 4pm for the ED front door team.
- Triple S visits which are informal and report to People and Culture committee quarterly
- Nursing professional judgment review presented to the Quality Committee in January 2025 and to the Board in May 2025
- The number of DOLs applications has been sustained at expected levels.

BAF Risk 2 – Quality and Safety

• The Trust continues to manage current pressures through an IMT approach. • A&E Delivery Board lead by an Executive Director ensures processes are in place to help co-ordinate the care of patients between community, primary care, NWAS and ELHT. • A&E and Acute Medical Unit improvement board, developed with alternative weekly executive review • Quarterly Divisional performance meetings where all elements of quality and performance are discussed. • Data and Digital Senate and Data and Digital Board are the forums for implementing and monitoring data and digital strategy.	**Specialist support, policy and procedure setting, oversight responsibility:** • Integrated Care Board (ICB) have confirmed their contract requirements in relation to Quality reporting monitored via monthly Quality Review Meetings. • Review and sign off of QIRA by medical director and chief nurse prior to implementation of any initiative • ICB Improvement and Assurance meetings (IAG), monthly executive to executive assurance meetings • Maternity and Newborn Safety Investigations (MNSI) (formerly Health Safety Incident Board) reports – review deaths and Health and Safety incidents. • Engagement meetings with Care Quality Commission (CQC) in place monitoring performance against the CQC standards. • Regular Updates on ICB EPRR. • Regular meeting with Specialist Commissioner for tertiary services (Vascular, HPB, Neonates) • ICB representatives attend Quality Committee, Mortality steering group, PSIRI **Independent challenge on levels of assurance, risk and control:** • CQC inspections and preparation/evidence gathering ongoing. Internal assurance processes evidencing performance against CQC Quality Standards have been aligned to the updated regulatory framework. • The Internal Audit Plan for 2025-26 agreed and underway with relevant quality and safety reviews being monitored through Quality Committee. • Regular Engagement meetings with General Medical Council (GMC). Coroner reviews of care provided through Inquest Processes. • Public Participation Panel (PPP) involvement in improvement activities and walk rounds. • Patient Safety Partners now participating in a quality governance meetings such as Venous Thromboembolism (VTE) Committee and Accessible Information Standards Task & Finish group. • Customer Relations Team undertaking recommendations from the Mersey Internal Audit Agency (MIAA) report into complaints management at ELHT. • PHSO complaints monitoring and external reports. Elective Care Recovery Board which includes regional and ICS level representation and scrutiny. • Quarterly Guardian of Safe Working report (GOSW) for junior doctors provided to the People and Culture Committee • JAG accreditation in Endoscopy • Regular GIRFT assessment and bench marking • Participating in GIRFT Further Faster 20 project. • Annual organ transplant report to NHSE • Review of MHUAC with Stakeholders • ICB Quality reviews of services • Burnley Hospital accredited surgical hub for adult and paediatrics (Nov 2025)

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Fragility and availability of the medical workforce Health and Wellbeing of the Workforce	As part of Waste Reduction Programme (WRP) work has commenced to identify opportunities to reduce agency and bank spend on medics. Focus on completed job plans. Service line reviews underway to identify gaps in demand and capacity To strengthen the Patient Safety Culture in line with the Workforce Plan and a Just Culture Approach.	Executive Medical Director/ Executive Nurse Director /Executive Director of People and Culture	Quarterly reviews with projected completion in March 2026.	Long term this has been partially achieved, and the Governance Assurance structure review completed and is being consulted on. Job Planning Scrutiny Committee focusing on productivity and VFM, recognising the need to increase effectiveness of medical workforce in support of individual medics achieving their job plans. PCB and ICB are working closely in addressing the fragile services identified across LSC. Compassionate Conversations approach introduced as part of leadership training module to support psychological safety whilst learning from mistakes has been embedded as part of leadership training. Strengthening of job planning scrutiny panel with support provided to CDs by medical staffing team in job planning. Trust's Q&S Team are providing support to the Staff Safety Group in relation to violence against staff.	A

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
2.	Provision of pathology services, with specific issues with histopathology within the Trust (medical and healthcare scientists)	Work is taking place across providers via mutual aid, facilitated via the ICB and external outsourcing and open recruitment. Improvement work within Cell Pathology has initiated to identify internal efficiency opportunities. Continued effort to appoint into Biomedical Scientist (BMS) and Medical Laboratory Assistant (MLA) vacancies in the department.	Executive Medical Director	March 2026	Good progress made in blood sciences to address staffing gaps and to support implementation of improvement work. Ongoing reduction of backlogs in histopathology and clear action plan in place to support ongoing improvement woprk via Trust Improvement Team and external support to review processes and team working to further identify improvement opportunities. Working with the pathology collaborative on benchmarking job plans and reporting activity across L&SC. Update papers presented to December Quality Committee and on Board agenda for January with final approval in March of contractual arrangements, due diligence, EIA, QIA and agreement in principle to transfer on 1 April 2026.	G
3.	Functionality of ePR causing issues with data quality, performance and affecting users capability to maximise the potential of the electronic system.	There is a need for relevant clinical document formats to be standardised and uploaded to Cerner eLancs team best use of resource needed to manage data cleansing and accuracy issues to enable timely reporting and performance monitoring and acting on change and service requests from staff/departments. Within current contract Upgrade of Cerner required to latest version to allow for access to new features and functionality. Data submission to national teams on activity, mortality, coding, audit to ensure that accurate and validated assumptions on income, HSMR/SHMI and activity. Quality of information added to the system remains an issue. Coding and quality and affect mortality indicators too.	Executive Medical Director	March 2026	Issues with ePR and Data Quality continue to be escalated and are being managed through the Data and Digital Senate/Board. Ongoing training is taking place with clinical/admin colleagues on the ePR. The Cerner upgrade has been approved in May 2025 and will be implemented in September 2025. Ongoing workstreams in place to address coding issues and refreshed mortality data now being received. HSMR data now received and part year data shows mortality score at 100 which is within expected levels. Clinical Lead with responsibility for GIRFT and Model Hospital working with Q and S team. Ongoing work with our East Lancs team, coders and the Mortality Steering Group (with deep dives into outliers). By 2030, the first of the One LSC provider Trusts will need to procure a new Electronic Patient Record (EPR) system. All of the provider organisations are working collaboratively on the outline business case. A refreshed Memorandum of Understanding (MoU) has been developed between the Lancashire and South Cumbria ICB and the region's NHS Trusts, replacing the 2021 version and building on previous collaboration agreements to support the digital strategy for 2024–2029. The MoU will be taken through each Trust's governance processes.	G
4.	The Quality Impact and Risk Assessment Process (QIRA) has been strengthened in light of the Trust financial recovery process but now requires independent review.	Constraints in finances will result in lack of investment into workforce, development of service, capital investment and revenue. This has the potential to negatively impact on quality and safety. The QIRA process has been strengthened but work is ongoing to fully align to the new Programme Management Office and will be independently audited via internal audit.	Executive Director of Finance / all Executive Directors	September 2025	Recovery director appointed to work with execs and teams in improving financial deficit. PMO office being established with help from PWC to manage delivery of schemes The Trust has re-reviewed and agreed a standardised QIRA process which is fully aligned to the processes of the PMO and the Waste Reduction Programme. The outputs are reported to Quality Committee to ensure sub-committee oversight. As part of the annual internal audit plan this process will be reviewed.	A
5.	Lack of capacity to manage increased activity across the Trust	Bed remodelling for managing increased activity Review of services to assess demand and capacity Work with Place based partners in improving patient pathways	Executive Director of Finance / Executive Medical Director / Executive Chief Nurse / Chief Operating Officer	September 2025	Established relationships through interface meetings with Place based leadership. ELHT is participating in the GIRFT faster forward programme Working with divisions on ensuring that that we capture activity levels. Working with national teams.	G

BAF Risk 2 – Quality and Safety

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Implement GIRFT and Model Hospital best practice approaches to care			Service line reviews taking place to determine demand & capacity, non commissioned services and productivity UEC improvement plan re-reviewed and updated for 2025/26	

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

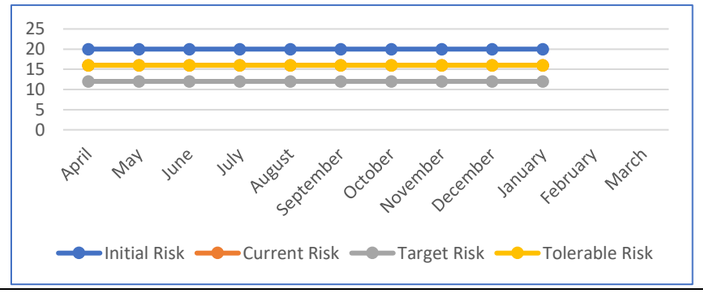
Risk Descriptor: A risk we don't achieve national access standards thereby causing harm, impacting on patient experience and increasing health inequalities.		**Executive Director Lead:** Chief Operating Officer / Chief Integration Officer	
Strategy: Clinical Strategy & Operational Strategy	**Links to Key Delivery Programmes:** Elective and Emergency Pathway Improvement	**Date of last review:** December 2025	**Lead Committee:** Quality Committee

Links to Corporate Risk Register

Risk ID	Risk Descriptor	Risk Rating	Direction of Travel
9336	Lack of capacity can lead to extreme pressure resulting in a delayed care delivery.	**15**	↓
8061	Patients experiencing delays past their clinical review date may experience deterioration	**16**	↔
10139	Lack of available theatres to manage emergency and elective patients (replaces DATIX ID 9895)	**15**	↔
10095	PAC issues impacting on efficiency and ability to meet targets and obstructive workflow	**15**	↔

Risk Rating (Consequence (C) x Likelihood (L)

Current Risk Rating: **C4 x L4 = 16**
Initial Risk Rating: C4 x L5 = 20
Tolerable Risk Rating: C4 x L4 = 16
Target Risk Rating: C4 x L3 = 12



Effectiveness of controls and assurances:

X	Effective
	Partially Effective
	Insufficient

Risk Appetite: Open/8-12

Controls in place to mitigate the risk:

Overall planning and delivery processes:

- Systems and processes in place to reduce health inequalities.
- Processes in place to risk assess and prioritise patients on the elective waiting lists and emergency care pathways for clinical harm.
- Annual business planning processes include forecasting of performance for all emergency and elective targets.
- Urgent and Emergency Care Delivery Board oversee the joint PLACE delivery and improvement plan with a focus on priority wards and integrated neighbourhood care.

Operational Management processes:

- Elective improvement plans for 2025-26 include diagnostic clearance plans and outpatient booking to ensure effective support for delivering the overall plan. Overseen by Elective Productivity Improvement Group.
- Emergency Care Improvement Group (ECIG) oversees UEC improvements in the Trust.
- System and processes in place with flow team and bed meetings for ongoing Situation Reports (SitRep) reporting with ongoing plans to strengthen discharge matron and patient flow facilitator role for supporting timely 7-day discharges
- Specific focus around Mental Health pathways with Lancashire and South Cumbria Foundation Trust (LSCFT).
- Activation processes in place for enhanced escalation during surge
- A clinically led safe discharge MDT steering group in place.
- Clinical engagement ensuring ownership for discharge planning on admission.
- Step-up (admission/attendance avoidance) and step down (timely discharge facilitation) care to maximise opportunities for admission avoidance and reduce demand for inpatient beds.
- Manage acute beds No Medical Criteria to Reside (NMC2R) to less than 10% of bed base with a stretch target of 5% of bed base.

Oversight arrangements:

- Weekly operational meetings to monitor progress against KPIs, chaired by COO /Deputy COO.
- Monthly outpatient improvement group chaired by the Executive Director of Service Development and Improvement.
- Theatre Utilisation Improvement Board in place and aligned with GIRFT requirements, targeting over 85% utilisation.
- The Chief Operating Officer and Deputy Medical Director for Performance hold support and challenge sessions with any specialties that do not achieve theatre utilisation trajectory.
- Elective Productivity and Improvement (EPIG) jointly chaired by Chief Operating Officer and Director of Service Development and Improvement to oversee the delivery of all elective care standards.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Clear trajectories for all key targets in place and monitored via reporting to weekly operational team meeting, executive team meeting, senior leadership group.
- Site meetings 7 days a week ensuring timely escalation of delays with corrective actions.
- Mobilisation of 24/7 IHSS service complementing the 24/7 ICAT service
- Health and Equalities Committee chaired by the Chief Nurse
- Clinical champions across all wards to promote best practice with discharge bundles. An electronic daily discharge dashboard has been embedded across all inpatient areas.
- Capped theatre utilisation has been sustained at a minimum of 85% since September 2024.

Specialist support, policy and procedure setting, oversight responsibility:

- Executives meet all with all divisions every morning (Monday – Friday) at 8.00am to address any issues for UEC and operational flow.
- Benchmarking data available from Getting It Right First Time (GIRFT), Model Hospital.
- Lancashire and South Cumbria oversight and co-ordination via Elective Activity Co-ordination Team, Elective Care Recovery Group, Lancashire and South Cumbria Chief Operating Officers meetings.
- System level plan monitoring at Pennine Lancashire via UECDB and Integrated Care Board (ICB) level via relevant system forums.

Independent challenge on levels of assurance, risk and control:

- Delivery of trajectories are monitored at ICB level through the monthly improvement and assurance meeting with the ICB

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

<table>
<tr><th>No.</th><th>Gap in controls and/or assurance</th><th>Action Required</th><th>Exec Lead</th><th>Due Date</th><th>Progress Update</th><th>BRAG</th></tr>
<tr><td>1.</td><td>Activity levels for 25/26 may not be achieved consistently.</td><td>The controls and weekly monitoring taking place to work towards the achievement of the 2025/26 activity plan (112.63% of 19/20 plan levels).</td><td>Chief Operating Officer</td><td>March 2026</td><td>A clear activity plan is in place for 2025-26 with productivity assumptions in place to support increased activity at reduced cost whilst maintaining income levels. This will be monitored through usual performance mechanisms but with an enhanced level of monitoring of associated income to ensure all activity is coded appropriately.</td><td>A</td></tr>
<tr><td>2.</td><td>The national ambition for NHS diagnostics in 2025/26, centres on improving patient access to diagnostic tests, reducing waiting times, and ensuring timely reporting of results.
Delays in diagnostic performance could impact on the delivery of RTT and Cancer standards</td><td>Implementation of Modality level delivery plans.
Monitor performance through weekly operational meetings
Monitoring of performance and waiting lists through divisional performance meetings</td><td>Chief Operating Officer</td><td>March 2026</td><td>ICS wide modelling completed, and discussions are ongoing around mutual aid to across the Lancashire and South Cumbria area ensuring patients have equity of access.
The Trust continues to perform better than the national average and a trajectory is in place to meet 2025/26 planning guidance requirements.</td><td>G</td></tr>
<tr><td>3.</td><td>Meeting Cancer Standards
National Ambition for the standards
62 day – 75% by March 2026
28 day – 80% by March 2026</td><td>Joint work with the Cancer Alliance on improvement
Continued Tumour site level detail to prevent backlog
Continued transparency of backlog delays at tumour site level for targeted preventative interventions
Weekly patient tracking with divisions for all tumour sites.
Agree trajectories to achieve new targets.</td><td>Chief Operating Officer</td><td>March 2026</td><td>Cancer action plan refreshed for 25/26 and monitored through the Cancer Steering Board Current submitted performance, against the National Ambition
<table><tr><td>Dec 25 IPR (Trust)</td><td>National Ambition by March 2026</td></tr><tr><td>62-day standard 73%</td><td>75%</td></tr><tr><td>FDS standard 78.40%</td><td>80%</td></tr></table></td><td>A</td></tr>
<tr><td>4.</td><td>Continued risk of >65 week RTT breaches and risk of not delivering a maximum of 1% < 52 week maximum wait by March 2026.</td><td>Demand and capacity at specialty review completed with improvement actions
With daily micromanagement.
Each directorate is setting an improvement trajectory which will be monitored through weekly operational meetings.</td><td>Chief Operating Officer</td><td>March 2026</td><td>There are daily meetings with divisional reps on managing all patients at risk of breaching 78 and 65 weeks.
Daily monitoring continues to maintain this position for 65 weeks performance
There is now focus on achieving a maximum of 1% of total patients on an RTT pathway waiting no more than 52 weeks.
Board approved recovery plan and trajectories in place for RTT. Approved 13 Oct 25 and submitted to NHSE.</td><td>A</td></tr>
<tr><td>5.</td><td>UEC
Reducing the number of patients waiting over 12 hours time in the ED Department</td><td>Improvement plan in place to support reducing the amount of time patients spend in the ED corridor this includes:
Streaming to alternative pathways
Admission avoidance via SDEC and IHSS
Use of escalation SOP when required in extreme pressures
Monitor the impact of any reduction in bed capacity</td><td>Executive Director of Integrated Care Partnerships and Resilience/ Chief Nurse</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to reducing the percentage of patients waiting over 12 hours in the ED depart from 17.8% to 15.2%
November performance was at 15.35%
The UEC improvement plan has been reviewed and updated for 2025/26 and work is ongoing with place partners.</td><td>G</td></tr>
<tr><td>6.</td><td>Ambulance handover times</td><td>As part of an LSC collaboration the Trust is working with NWAS colleagues to improve ambulance handover times, to an average of 24 mins and to be better than the NWAS average handover time</td><td>Executive Director of Integrated Care Partnerships and Resilience /Chief Operating Officer</td><td>March 2026</td><td>As part of the 2025 – 2026 planning, the Trust is committed to improving average ambulance handover time to 24 mins
Working collaboratively with NWAS colleagues on handover times. There are dedicated meetings with NWAS & ELHT staff on a collaborative approach to improvement.</td><td>A</td></tr>
</table>

BAF Risk 3 - Elective Recovery and Emergency Care Pathway

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					November 2025 average handover time was 22 mins - Percentage of patients with a handover of >30 mins 14.66%	
7.	Discharge 2% more patients on discharge ready date (84% > 86%) Improve average delay in discharge to 4.5 days from 5 days	Embedding of the discharge dashboard to support reduction in longer length of stay and not meeting criteria to reside	Executive Director of Integrated Care Partnerships and Resilience /Chief Nurse	March 2026	Discharge optimisation group established March 2025 under the leadership of the Divisional Medical Director for CIC and Divisional Director of Nursing for MEC	A

BAF Risk 4 – Culture Workforce Planning & Redesign

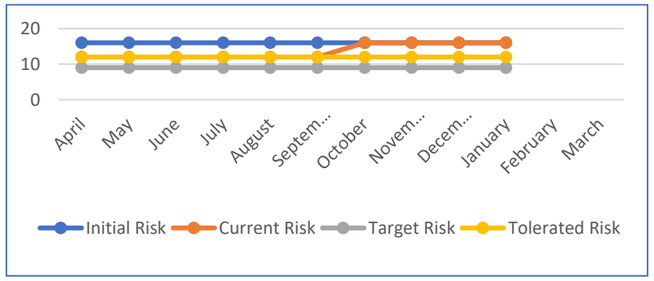
Risk Description: The Trust is unable to deliver its strategic objectives as a result of its inability to sustainably transform the workforce.		**Executive Director Lead:** Interim Chief People Officer	
Strategy: People Plan	**Links to Key Delivery Programmes:** People Plan Priorities, Financial Recovery Priorities, Improvement Priorities.	**Date of last review:** December 2025	**Lead Committee:** People and Culture Committee

Links to Corporate Risk Register:

Risk Number	Risk Descriptor	Risk Rating
9746	Inadequate funding model for research, development and innovation	**16**

Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: **C4 x L3 = 16**
Initial Risk Rating: C4 x L4 = 16
Tolerated Risk Rating: C4 x L3 = 12
Target Risk Rating: C3 x L3 = 9



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Pursue/High

Controls in place to mitigate the risk –

- **Freedom to Speak Up (FTSU)** arrangements remain embedded, with the Guardian and Ambassadors in place. Reporting continues through the Staff Safety Group, People & Culture Committee, and Trust Board, and activity has been expanded to strengthen the visibility of FTSU in divisional and team-level settings.
- The **ICB People Committee** has developed and agreed a revised workforce strategy, supported by Professional Working Groups (PWG) that report into PCB ExCo. Operational issues raised at system forums are now routinely escalated into the Executive Team for resolution, ensuring quicker response and stronger alignment across the LSC system.
- The **Trust People Plan** is actively delivered through the Senior Leadership Group (SLG), Divisional Management Boards (DMBs), and Divisional Performance meetings, with assurance provided through the People & Culture Committee (PCC). Work with the Recovery Support Programme (RSP) has focused on strengthening metrics, with improvements now being tracked through divisional packs and reported via the Integrated Performance Report (IPR).
- A refreshed **Grip and Control action plan** is in place and reviewed through PCC, ensuring workforce metrics are consistently monitored. Key focus areas include variable pay, sickness absence, and retention.
- **Workforce Waste Reduction Programme (WRP) meetings** are held weekly with clinical and corporate divisions, and fortnightly with corporate teams, to track delivery against agreed trajectories. Progress is closely monitored, with escalation routes now well established through the oversight group chaired by the CPO.
- **Vacancy control processes** have been further strengthened, with weekly panels in place and final sign-off for new roles retained at Executive Team level. This has brought greater discipline to establishment control and improved links between workforce, finance, and activity.
- A shared **HR framework** was launched in March 2025 to support workforce transformation across the LSC system. Fortnightly meetings of system workforce leads ensure consistency of application and provide a platform for shared learning.
- A **service and redesign support offer** has been rolled out across services to identify productivity and transformation opportunities. This is supported by best practice guidance to reduce variable pay, rapid improvement weeks focused on high-use staffing areas, and a manager's toolkit to strengthen control.

Assurance that the controls are effective –

- **Service delivery and day-to-day management of risk and control**
- The **Staff Safety Group** continues to oversee operational risks and interventions to ensure staff safety matters are addressed promptly, with divisional links strengthened to escalate emerging issues.
- **Divisional Pay Control meetings** now provide closer scrutiny of variable pay, vacancy management, job planning, annual leave, and overpayments, with escalation to the workforce oversight group where required.
- **Staff Networks** (eight in total, covering all protected characteristics) remain well supported, each with an Executive Sponsor and Non-Executive Champion. These networks provide rich insight and report formally through the Inclusion Group.
- **Freedom to Speak Up (FTSU) Ambassadors** are fully embedded across the organisation, supporting the Guardian and increasing accessibility of the service. FTSU activity is now incorporated into mandatory training, with October 2025 marked as FTSU Month to raise awareness Trust-wide.
- **Workforce dashboards** are in routine use at divisional and Trust level, tracking sickness absence, variable pay, headcount and workforce availability. Additional analytical capacity from the Recovery Support Programme (RSP) is strengthening assurance through divisional packs and PCC reporting.
- **EDI metrics** are reported annually to Board and tracked quarterly through PCC, with divisional EDI data packs actively used in performance reviews.
- The **Team Engagement and Development (TED) Tool** continues to be rolled out, enabling teams to assess and act on their own culture, staff survey results and absence data, with targeted OD support deployed to areas of concern.
- The **Behaviour Framework** is now fully embedded in recruitment and appraisal processes. Dedicated frameworks for anti-racism and sexual safety have been developed and are being rolled out.
- **Appraisal and training compliance** is monitored closely through performance meetings and QAAF assessments, with wellbeing conversations a standing element of the appraisal process. Managers are encouraged to maintain regular check-ins with staff, supported by Project M, which continues to provide wellbeing support and development for managers.

BAF Risk 4 – Culture Workforce Planning & Redesign

• **Partnership working with trade unions** has been reinforced, with JNCC and JLNC providing mature and constructive oversight of organisational change and workforce policy. Engagement has been central to progressing service reviews and supporting staff through change. • The **Health and Wellbeing Strategy** continues to lead ICS priorities on enhanced wellbeing and occupational health, with ELHT chairing the system-wide women's health and mental health workstreams. A focused "Managing Attendance and Wellbeing" scheme is now fully embedded, with targeted interventions on long-term sickness, rapid access to psychological support, and reasonable adjustments. • **Directorate of Education, Research, and Innovation (DERI) Strategy** clearly articulates the ambition of the Trust to support workforce, research and innovation to make the Trust a more attractive place to work. DERI reporting to the PCC. • **Employee Sponsor Group** chaired by the Chief Executive working with divisions to address improvements to culture and staff experience as measured by staff survey. Staff stories come to the Committee to enable triangulation of data with staff experience. • **Inclusion Group** chaired by the Chair leads oversees inclusion and belonging priorities. • **Anti-Racism project** established with support from the improvement team. • **Reasonable adjustment improvement project** – key metrics agreed and are tracked and reported to People and Culture Committee. • **Exec led divisional performance meetings** oversee delivery of objectives and strategies including workforce metrics at divisional level.	• **Leadership and OD activity** has been aligned with the Safe, Personal, Effective Plus (SPE+) Improvement Practice, ensuring leadership development supports wider improvement priorities. • **Recruitment, retention, and staff in post data** are routinely reported through the IPR and PCC. • **Job planning and e-rostering** for medical staff are being more tightly linked, improving transparency and oversight. • **Variable pay controls** are firmly embedded and monitored through WRP meetings, ensuring robust oversight of bank and agency shifts. • **Exit interview processes** are systematised, with reporting now available through HR to track trends and identify hotspots for targeted action. • **Specialist support, policy, and system collaboration** • The **HR Directors Group** across the ICS continues to shape the system workforce agenda, aligning local Trust priorities with wider system collaboration. • The **ICS EDI Collaborative** supports development and spread of best practice, with ELHT actively contributing. • The **Trust Wellbeing Lead** chairs the system wellbeing group, working to standardise approaches across the ICS. • The **ICS Culture and Belonging Strategic Group** is established, providing a system forum for alignment on culture priorities. • The **Trust Chair and NED EDI Lead** participate in the regional BAME Assembly, ensuring staff voice informs strategy. • **PMO support** is embedded to strengthen delivery of Trust-wide workforce schemes linked to financial recovery. • **Independent challenge and external assurance** • **WRES and WDES results** provide national benchmarking, with time-bound action plans monitored through PCC. • **EDS 2022** completed at system level with input from patient, community, staff side and voluntary groups. • The **National Staff Survey** continues to benchmark performance against regional and national comparators, with divisional feedback sessions in place. • The **annual Workforce Plan submission** is triangulated with finance and activity data and aligned to the clinical strategy, monitored through the ICB. • **Bank and agency spend** is monitored by NHSE and the ICB, with ELHT remaining within the cap since October 2023 and with no off-framework use since August 2023. • **Internal audit reviews** include workforce elements within the 2025–26 plan, with follow-up tracked through the Audit Committee and PCC. • **System-level oversight** of bank and agency spend is provided through the CPO Professional Working Group. • **Vacancy control panels** at both Trust and ICB level continue to provide assurance on recruitment discipline. Vacancy control panels executive led now weekly. • **Monthly IAG meetings** with the ICB scrutinise workforce KLOE, providing an additional layer of external challenge. • **Workforce Oversight Group** – chaired by the CPO have now commenced. This group meets fortnightly and is intended to have the strategic oversight of all schemes. Each meeting has a deep dive on a specific programme of work in addition to general overview of all programmes of work.

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Financial recovery – development and full delivery of workforce schemes needed to close the gap given NOF 4 status.	Ensure timely development and delivery of workforce schemes to close the gap in meeting financial recovery targets recurrently. Support for those impacted by change and change readiness programme. Review of organisational change policy and support.	Executive Director of People and Culture	May 2025 and monthly review.	• Workforce schemes fully developed and account for 42% of all WRP schemes – reviewed through PMO and reported monthly to Improvement and Assurance Group (IAG). • Weekly Waste Reduction Programme (WRP) meetings established. Daily management dashboards produced. • Variable pay – rapid improvement weeks held, weekly initially, now fortnightly – targeting highest users of temp staffing. • HR Framework team stood up - MARS scheme implemented. • Review of organisational change policy in partnership with staff side to tighten up controls around redeployment. • Service reviews continuing with selected areas of Trust. • Fortnightly oversight group chaired by CPO to oversee all workforce schemes • Increasing vacancy control panels to weekly. • Implementing daily variable pay group.	A
2.	Risk of increased staff absence and burnout leading to use of bank and agency workers and higher turnover which impacts on morale and quality of patient care.	On-going delivery of the ELHT People Plan underpinned by a compassionate and inclusive culture.	Executive Director of People and Culture	A milestone report will be provided to the People and	• PID and QIRA produced for management of sickness absence scheme under review by Interim joint CPO. • Continued development of mental health pathways and interventions as recommended by the external review.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
		Continued roll out of Health and Wellbeing Strategy with focus on women's health, developing the mental pathway and on reasonable adjustments. Targeted work through Employee Sponsor Group and People Experience MDT to work with teams and divisions. Attendance Management and Wellbeing Management Scheme. Continue to roll out restorative clinical supervision and train up more professional nurse advocates to meet the target ratio of PNAs to staff members.		Culture Committee in July 2025	• PCB OH and Wellbeing services have carried out a procurement exercise for a common IT platform in readiness for the future model, contract to be signed and plans need to be developed to migrate all Trusts on to the new system. • Project M – a peer support group for line manager wellbeing was launched in January 2024 by the CEO and now well embedded. • Recruitment to central resource to support reasonable adjustments completed. • Training for managers in attendance management and reasonable adjustments, review of how this is monitored and whether this is made mandatory for all managers. • MDT on track with divisional feedback of staff survey results and to identify the 3 cultural themes and teams for in-reach support. • Recruiting to further cohorts of PNA training. • Mental Health Network and Well Team response to recommendations of review into psychological wellbeing service and support including for line managers. • Shared learning from LTH being embedded. • Scheme will report to the fortnightly workforce oversight group	
3.	Risk of loss of service due to national industrial action.	Ongoing monitoring and management of actions through Industrial Action Cell as required.	Executive Director of Integrated Care, Partnerships and Resilience	N/A	• The **resident doctor 5-day strike in July 2025** had a disproportionate financial impact at ELHT, estimated at **£700–£800K compared to around £400K at LTH**. This may, in part, be due to differences in activity coding. The impact is being reviewed in detail to inform future levels of staffing, income, and activity planning, particularly as further resident doctor strikes cannot be ruled out. • **Nursing staff** have rejected the 3.6% pay award in an indicative ballot. A formal strike ballot is expected in Autumn 2025, which could present a further risk of disruption if industrial action is confirmed. • The **BMA Consultants Committee** has concluded an indicative ballot following the rejection of a 4% pay offer. The results demonstrated a positive favour towards strike action, although no formal ballot has yet been announced. • **Talks between the BMA and government remain ongoing**, which is encouraging and may help prevent escalation to formal industrial action. However, the situation remains dynamic and continues to be closely monitored at both Trust and system level. • **F1 doctors** have been notified that they are being balloted separately, adding further uncertainty to the overall industrial relations landscape.	n/a
4.	Risk of impact of colleagues experiencing discrimination, abuse and harassment from colleagues, managers and patients	Development of compassionate and inclusive culture. Trust becoming anti-racist. Greater cultural competence of line managers who line manage internationally educated colleagues. Sexual safety project to be fully implemented. Closing the gap of experiences between colleagues who have a protected characteristic and those without. Process for reasonable adjustments to be centralised, greater visibility of those requesting reasonable adjustments and outcomes. Implementation of EDI Improvement Plan, with shared accountability for implementation. Performance Appraisals –inclusion objectives	Chief People Officer	An update report on Aarushi Project came to Board in September 2025 Integrated action plan to be presented in October 2025 at PCC. Then quarterly updates.	• The **ED&I performance report** and **integrated action plan** continues to be shared with the Inclusion Group. Further analysis is underway in areas where metrics require improvement, and targeted action plans have been agreed. • The **Aarushi Project update** was presented to the Board in September 2025 and was **very well received**, reinforcing organisational commitment to tackling racism and improving inclusion. • The Trust has achieved the **Bronze Award** for anti-racism and has developed a **Silver-level action plan**, which is now in delivery. • A **joint statement of commitment** has been agreed with the University of Lancashire, strengthening collaboration on shared inclusion priorities. • A new **EDI training brochure** has been finalised, setting out a prioritised training offer. This includes the **relaunch of allyship and anti-racism training** from August 2025, following a temporary pause due to financial pressures.	A

BAF Risk 4 – Culture Workforce Planning & Redesign

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
					• The **inclusive recruitment toolkit** pilot has been completed, with bite-sized training now available. Work is ongoing with One LSC to agree a sustainable delivery model. • The **Trustwide Anti-Sexual Harassment and Safety Task and Finish Group (TAFG)** has been established, with e-learning in place and policy updates scheduled through Policy Group, JNCC, and JLNC. • The **EDS 2022 assessment** has been completed and reported. Next steps focus on embedding actions into divisional plans and tracking progress through committees, including health inequality committee. • New **posts to support disability and reasonable adjustments** have been recruited, ensuring consistent practice and improved monitoring. • The **Employee Experience MDT** continues to work with divisions, identifying cultural themes and leading in-reach support, with a particular focus on **sexual safety in Theatres and ED**. • Work is underway to **review and realign staff networks**, ensuring they are strategically focused and supported to deliver measurable improvements. • A **roundtable with key stakeholders** is being planned to agree the next strategic steps for inclusion, building on recent achievements and the Aarushi Project's momentum with focus on equal pay.	

BAF Risk 5 – Financial Sustainability

Risk Descriptor: The Trust is unable to deliver its agreed financial recovery plan.

Executive Director Lead: Executive Director of Finance

Strategy: Finance Strategy

Links to Key Delivery Programmes: Waste Reduction Programme

Date of last review: December 2025

Lead Committee: Finance and Performance Committee

Links to Corporate Risk Register (CRR):

Risk ID	Risk Descriptor	Risk Score
10082	Failure to meet internal and external financial targets	20

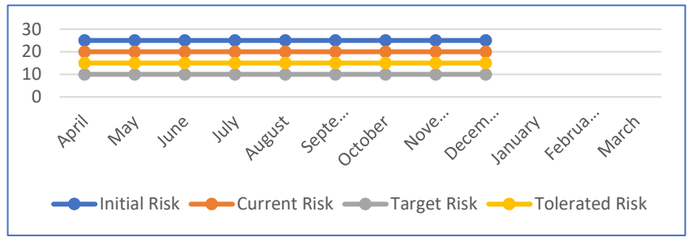
Risk Rating (Consequence (C) x Likelihood (L)):

Current Risk Rating: C5 x L4 = 20

Initial Risk Rating: C5 x L5 = 25

Tolerated Risk Rating: C5 x L3 = 15

Target Risk Rating: C5 x L2 = 10



Effectiveness of controls and assurances:

	Effective
X	Partially Effective
	Insufficient

Risk Appetite: Cautious/4-6

Controls in place to mitigate the risk:

Organisation

- A full review of the financial accountability meeting structure has taken place to make the best of use of time
- A Programme Management Office (PMO) has been established. The PMO focuses on monitoring progress of plans and implementation to support financial recovery including grip and control, workforce plan and waste reduction programme across the range of cross-cutting groups and divisions including corporate and OneLSC forces groups.
- There is a revised Grip and Control process both implemented and being further strengthened, including a review of the external audit across a wider range of measures, separate investigations to curtail discretionary spend and a new panel process in conjunction with OneLSC to control spend
- The trust has established a Financial Improvement group which meets fortnightly chaired by the CEO to assess progress and challenge delivery. This includes oversight of the Trust's NOF4 exit criteria, WRP and Grip and Control
- A Vacancy Control Panel is in place at divisional and Trust level and this is being further strengthened with additional review fields and a shift to a weekly process
- A variable pay panel is being established to replicate LTH process chaired by the CPO meeting daily to assess spend decisions around key bank and agency areas
- Non-Pay will be assessed by a daily central panel and daily divisional panels using revised cost control criteria in conjunction with the trusts requisition process
- A weekly Pay Control Group, chaired by the Deputy DoF, is in place that reviews the oversight and process behind all payments to staff and contractors.
- The Financial plan for 2025-26 has been developed via the annual planning process and was approved by Trust Board prior to National Submission. This takes account of the Trust's required Control Total and financial improvement.
- The Trust Standing Financial Instructions (SFI's) are reviewed annually and updated for any national guidance and regulations.
- The financial position, forecasting for the year, capital spend against programme and progress towards achievement of the Waste Reduction and Financial Improvement Programme (WRP & FIP) are reported and scrutinised through Financial Improvement Group (FIG), the PMO Head of Finance, PMO/Finance validation processes, CFO, Deputy Director of Finance, and the Finance and Performance Committee.
- Service Reviews are taking place to support services to identify cost reduction opportunities
- Communication about the financial challenge and actions being taken is being led from the Executives, including PMO messaging, Roadshows, the Recovery Director, use of Intranet, wider media, the regular Team Brief, and through the senior leadership of the Trust.

Assurance that the controls are effective:

Service delivery and day to day management of risk and control:

- Delivery of financial plan scrutinised via the revised PMO governance in place, FIG and Finance and Performance Committee with key risks identified as a live RAID document aligned to the WRP delivery tracker and wider finance reporting/oversight
- Corporate Risk Register updated for latest financial risks facing the organisation with action plans in place to mitigate
- Divisional, Trust wide and system Waste Reduction Programmes continue to be developed, where there is a fully developed plan in delivery; Quality Impact Risk Assessments (QIRAs) are completed for all schemes and signed off by the Chief Nurse and Medical Director without which schemes cannot appear on the tracker unless a QIRA is not required; and PMO is strengthening assurance on delivery through robust processes via completion and assessment of Project Initiation Documents
- Grip and Control Assessment undertaken by PWC, a Grip and Control action plan has been signed off by Audit Committee, Finance and Performance Committee and Trust Board and reviewed at FIG. Further significant 'strengthening' around process, budgetary removals, requisition processing and panels in commencing; separate investigations are underway to identify high areas of discretionary spends and resulting actions to halt this
- In-depth review of the additional financial pressures identified in year have been determined. Mitigations etc will be reported through Finance and Performance Committee.

Specialist support, policy and procedure setting, oversight responsibility:

- Joint Finance Improvement Programme Directors in post until 31st March 2026, accountable to the CEO.
- Director of Finance has engaged with PwC who have agreed to undertake a 'critical friend' review of the financial recovery arrangements in place, as agreed at the October IAG. This is to be inclusive of ELHT PMO and wider leadership team.
- PwC as undertaken three significant phases of work to support the initial process set up and identifications of opportunity to convert into WRPs.
- A Programme Management Office (PMO) is now in place with internal appointments but also supported by both an external PMO head of finance and a Head of PMO in place with processes, architecture, reporting and controls now in place across delivery of the Waste Reduction and Grip ad Control programme
- Corporate collaboration – full participation in all areas and opportunities identified.
- The Trust and LSC system has a NHSE nominated lead who is working with the LSC System up to summer 2025.
- PwC is working with the Trust and the LSC System as the system entered formal regulatory intervention.

BAF Risk 5 – Financial Sustainability

<u>System</u> • System finances monitored through System Finance Group (includes representation of all providers and Integrated Care Board (ICB)) to facilitate understanding and actions associated with the overall system financial position. • One LSC Central services collaborative programme underway with ELHT as the host. • System financial controls implemented. • Assurance and oversight in place with the System Turnaround Director and the supporting team and NHSE.	• A financial governance review took place in January 2025 with an action plan agreed, which is monitored via Audit Committee. <u>Independent challenge on levels of assurance, risk and control:</u> • The Trust is part of the NHS Oversight Framework Segment 4 Recovery Support Programme • Internal audit plan was agreed at Audit Committee May 2025 and underway. External audit of accounts to be presented to Audit Committee in June 2025. • Counter fraud workplan for 2025-26 agreed at Audit Committee April 2025, regular progress reported to Audit Committee • One NHS Finance Towards Excellence Accreditation 3-year reaccreditation was awarded in October 2024

No.	Gap in controls and/or assurance	Action Required	Exec Lead	Due Date	Progress Update	BRAG
1.	Inadequate funding for the services commissioned	Work with the ICB on the funding for the services commissioned, in line with the NHS Payment Services guidance.	Executive Director of Finance	Q4 2025/26	A position for 2025/26 has been concluded with deficit support funding agreed for various services whilst further reviews take place. Work is now ongoing with commissioners to review as part of planning and contracting for 2026/27.	A
2.	No signed Contract for 2025-26	To work with the ICB to agree the contract disputes	Executive Director of Finance	End of July 2025	Contract values agreed and all elements of accompanying schedules. Awaiting final issue of contract by the ICB to enable signature. The contract was signed in September 2025 for £691m.	B
3.	The financial plan will not be met in 2025-26 with a further risk that Deficit Support Funding is withdrawn and overall impact on cash position	To work collectively across with the Trust and with external support to help to turnaround the financial position and financial recovery.	Executive Director of Finance	Monthly updates. End March 2026	Additional measures are in place with additional control groups in place increasing grip and control across pay and non-pay. Joint Finance Improvement directors in post until 31st March 2026 accountable to the CEO for the leadership of WRP. PMO established, monthly reporting and check and challenge in place. FIG established and cross cutting workstreams. Work ongoing to further populate the WRP pipeline to support mitigations. Divisions reviewing and updating forecasts and establishing recovery plans where needed. Ongoing monitoring of cash position and forecasting including application for cash where required. Cash support requested in December 2025.	A

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/016
Report Title:	Education Research and Innovation Committee Terms of Reference		
Author:	Susan Giles Interim Director of Corporate Governance		
Lead Director:	Neil Pease Interim Joint Chief People Officer		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**To Approve**	**For Information**
			✓	
Executive Summary:	Responsibility for education, research and innovation currently sits within the remit of the People and Culture Committee. Following a review of the Committee's workload it has been agreed with the Chair and relevant Executive Leads that an Education, Research and Innovation Committee of the Board should be established. The primary purpose of the Committee will be to provide the Board with assurance in relation to the development and delivery of the education, research and innovation strategy.			
Key Issues/Areas of Concern:	Having a dedicated Board committee for education, research and innovation will ensure a greater level of scrutiny and oversight of all risks.			
Action Required by the Board:	The Board is asked to approve: • the establishment of the Education, Research and Innovation Committee; and • the proposed terms of reference for the Committee.			

Previously Considered by:	
Date:	
Outcome:	

EDUCATION, RESEARCH AND INNOVATION COMMITTEE TERMS OF REFERENCE

1.0 Constitution

1.1 The Board of Directors ("the Board") has established a Committee with delegated authority to act on its behalf in matters relating to education, training, research, innovation and governance to be known as the Education, Research and Innovation Committee ("the Committee").

1.2 The Committee is a non-executive Committee accountable to the Board and has no executive powers, save any expressly provided within these terms of reference.

2.0 Authority

2.1 The Committee is authorised by the Board to:

2.1.1 Investigate any activity within its terms of reference.

2.1.2 Seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

2.1.3 Obtain independent professional advice and to secure the attendance of external advisors, within the parameters of the Scheme of Delegation, with the support of the Director of Corporate Governance; and

2.1.4 Approve such policies and procedures within the remit of the Committee as may be assigned by the Board.

3.0 Purpose

3.1 The primary purpose of this Committee is to have grip and control of education, research and innovation related matters across the Trust to provide assurance or escalate concerns to the Board.

3.2 Specifically the Committee will:

3.2.1 Oversee the development and implementation of the Trust's Directorate of Education, Research and Innovation (DERI) Strategy and recommend it to the Board for approval.

3.2.2 Monitor the delivery of any Trust-wide education, research and innovation metrics and associated performance measures, identifying and understanding any significant variation and ensuring an appropriate response.

3.2.3 Provide assurance to the Board on the development, implementation and review of the DERI plans; and

3.2.4 Monitor education, research and innovation aspects of the Annual Plan.

4.0 Responsibilities

4.1 To fulfil its purpose the Committee will:

4.1.1 Obtain assurances that the Trust's education, research and innovation plans support the annual objectives of the organisation

4.1.2 Contribute to the development of an effective education, research and innovation strategy that is aligned to the clinical strategy and financial sustainability of the Trust, and make appropriate recommendations to Board for approval.

4.1.3 Receive assurance on behalf of the Board that the Trust's education, research and innovation policies satisfy relevant standards and guidance issued by regulators, Royal Colleges and other professional and national bodies.

4.1.4 Assure the Board of compliance with key national and statutory education, research and innovation requirements, including the 10 Year Health Plan for England

4.1.5 Receive assurance that all education and research income is governed, effectively managed, in accordance with contractual agreements, and utilised appropriately to meet the Education, Research and Innovation Strategy.

4.1.6 Receive assurance about quality of multi-professional placement provision

4.1.7 Receive assurance that there is effective education, research and innovation governance

4.1.8 Promote a culture of continuing professional education and learning and development for all staff within ELHT.

4.1.9 Receive Chair reports from sub-groups set out below in respect to areas of concern, seeking assurance that robust timely action plans are in place to resolve concerns;

4.1.10 Escalate to the Board any significant concerns about education, research and innovation within the Trust; and

4.1.11 Oversee the strategic and operational education, research and innovation risks aligned to the Committee on the Board Assurance Framework and Corporate Risk Register by:

i) Monitoring the effectiveness of the controls and assurances in place and progress against the agreed risk mitigations ensuring that they address gaps in control and assurance;

ii) Commissioning deep drive reviews for any risk within the Committee's remit;

iii) Referring appropriate risk matters to the Audit Committee for their

consideration.

5.0 Membership

5.1 The Committee will comprise the following membership:

- Three Non-Executive Directors, one of whom shall be chair
- Executive Director of People & Culture
- Executive Medical Director or Chief Nurse
- Executive Director of Finance
- Executive Director of Service Development and Improvement

5.2 Only voting Board members have the right to vote at meetings.

5.3 Members are expected to attend at least 75% of meetings.

5.4 The Chief Executive has a standing invitation to attend any meeting of the Committee.

5.5 Other Executive Directors may be invited to attend the Committee for specific items.

6.0 In Attendance

6.1 The following will be in regular attendance at meetings:

- Director of Corporate Governance
- Deputy Director of Education, Research and Innovation
- Deputy Director of Finance
- Deputy Director of People & Culture
- Director of Medical Education
- Director of Research
- Head of Education
- Head of Research
- Partnership Officer

6.2 Persons in attendance will not have voting rights.

6.3 The Committee Chair may also extend invitations to other individuals with relevant skills, experience, or expertise as necessary. Any such individuals will be in attendance only.

7.0 Quorum

7.1 A quorum will comprise four members including at least two Non-Executive Directors and two Executive Directors.

7.2 In the event that the Chair is unable to attend one of the other Non-Executive Directors shall chair the meeting.

7.3 In the event that a Non-Executive Director is unable to attend, any other Non-Executive Director can be invited to attend as a substitute voting member.

7.4 Associate Non-Executive Directors and non-voting Executive Directors continue as non-voting members but do count towards the quorum of the Committee.

7.5 Executive Directors who are unable to attend may nominate deputies who are able to contribute and make decisions on their behalf as a substitute voting member. Any such deputies will count towards the quorum.

8.0 Frequency

8.1 The Committee will meet at least 6 times per year. Additional meetings may be called at the discretion of the Chair of the Committee.

9.0 Administrative Arrangements

9.1 The Committee will have in place an annual work programme, which will be aligned to the responsibilities set out within the terms of reference and the Trust's annual objectives set by the Board. The Director of Corporate Governance/Company Secretary will ensure that the work programme is regularly updated throughout the year.

9.2 The Committee will receive the papers for meetings a minimum of 5 working days prior to the meeting.

9.3 Administrative support for the Committee will be provided by the Corporate Governance Team.

10.0 Reporting to the Board

10.1 The Committee will report to the Board via the Committee Chair and the presentation of a 'Triple A' (Assure, Advise, Alert) report.

10.2 Key workforce metrics will also be monitored at every Board meeting as part of the Integrated Performance Report.

10.3 The Committee will provide an annual report to the Board setting out how it has fulfilled its terms of reference throughout the year, providing an overview of the assurances received and making any recommendations to improve the effectiveness of the Committee.

11.0 Relationship with other Board Committees

11.1 The Committee will communicate with other Board Committees via common membership and the formal escalation of any issues via Committee Chairs and/or the Director of Corporate Governance/Company Secretary.

11.2 The Chair of the Education, Research and Innovation Committee will be a member of the Audit Committee to ensure that there is a direct link to and from the Audit Committee.

11.3 Where a matter relating to education, research and innovation has a significant financial implication the Committee will refer that matter to the Finance and Performance Committee for consideration.

11.4 Where a matter relating to education, research and innovation has significant quality implications, the Committee refer that matter to the Quality Committee for consideration.

12 Reports from Sub-Committees

12.1 The Committee may commission, receive and review advisory and assurance reports and improvement plans from the following groups:

- Education & Innovation Operational Delivery Board (EIODB)
- Research & Innovation Operational Delivery Board (RIODB)

13 Review

13.1 The Committee shall review its effectiveness on an annual basis, escalating any recommendations for change to the Board.

13.2 The Board will formally review the terms of reference for the Committee at least every two years.

Education, Research and Innovation Sub-Committee Structure

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST BOARD REPORT

Meeting Date:	14 January 2026	**Agenda Item:**	TB/2026/017
Report Title:	Risk Management Strategy and Framework 2025-28		
Author:	Mr J Houlihan, Assistant Director of Health, Safety and Risk		
Lead Director:	Dr J Hobbs, Executive Medical Director		

Purpose of Report:	**To Assure**	**To Advise/ Alert**	**For Decision**	**For Information**
			✓	
Executive Summary:	The Risk Management Strategy and Framework 2025-28 sets out the Trust's strategic approach to identifying, assessing, mitigating and monitoring risks across all services. It strengthens governance, clarifies roles and responsibilities, and introduces updated escalation protocols to support consistent and effective risk management. Aligned with statutory requirements, national and international guidance, the framework underpins the delivery of safe, personal and effective care and enhances organisational resilience. The strategy has been reviewed and endorsed by key governance groups, and Board approval and ratification are now recommended to ensure a unified and robust approach to risk management across the Trust.			
Key Issues / Areas of Concern:	The updated framework strengthens governance through clearer accountability, alignment with national standards and enhanced tools for identifying, assessing and escalating risks. It also introduces an improved training and competency model to support consistent application across the Trust. Implementation will require coordinated integration of updated risk appetite statements, alongside addressing variation in risk maturity, ensuring ongoing assurance of internal controls, and embedding a proactive enterprise-wide risk culture. Capacity and resource pressures may also influence the consistency and timeliness of risk monitoring and reporting.			
Action Required by the Committee:	The Board is asked to: 1. Approve and ratify the strategy and framework 2. Endorse the implementation plan and monitoring arrangements including quarterly updates to the Board 3. Delegate authority to the Audit and Risk Committee and Executive Lead for any minor amendments during or after implementation			

Previously Considered by:	Audit and Risk Committee
Date:	13 October 2025
Outcome:	The Committee approved the Strategy and endorses it to the Board for approval.

Risks and Impact of Taking / Not Taking Action

1. Failure to approve and implement the Risk Management Strategy and Framework 2025-28 presents a high impact, high likelihood risk to the Trust's ability to manage strategic, operational and clinical risks effectively. Without a unified framework, the Trust may face regulatory non-compliance, including potential escalation by the Care Quality Commission or NHS England, alongside reputational damage, increased incidents and weakened organisational resilience. Fragmented risk practices could undermine the reliability of internal controls, impair decision making and reduce assurance to the Board.
2. Timely approval will enable a proactive, integrated and intelligence led approach to risk management, strengthening governance, improving continuity planning and supporting the delivery of safe, personal and effective care. It will also enhance the Trust's ability to anticipate emerging risks, including digital, workforce and environmental challenges.

Relation to Quality and Safety, Operational Performance, Compliance, Finance, Workforce and Stakeholders

3. The Risk Management Strategy and Framework 2025-28 directly supports the Trust's Quality Strategy, Health and Safety Strategy, Patient Safety Incident Response Framework (PSIRF), and People Strategy. By embedding structured processes for risk identification, assessment and mitigation, it enhances patient and staff safety, strengthens clinical standards, and supports a culture of openness and learning.
4. Operational resilience will be improved through enhanced continuity planning and crisis response mechanisms. The framework ensures compliance with statutory and regulatory requirements, including the Health and Safety at Work etc. Act 1974, CQC Fundamental Standards, and NHS England governance expectations.
5. Financial risks will be more effectively controlled through improved forecasting, cost avoidance, and reduction in claims exposure. For the workforce, the framework clarifies roles and responsibilities, supports a just culture, and provides targeted training and development. It also strengthens transparency and accountability, building confidence among patients, staff, regulators, ICS partners and wider stakeholders

Mitigations and timelines

6. Implementation will commence in Q4 2025-26 following Board ratification. A structured implementation roadmap will be overseen by the Executive Risk Assurance Group (ERAG), with clear milestones, responsible leads and dependencies identified.
7. Alongside workshops, a comprehensive training and communication programme will be launched in Q4 to build capability across all levels of the organisation. From Q1 2026-27, strengthened KPIs and annual reviews will be embedded into governance processes to monitor effectiveness and compliance. Risk appetite statements will be reviewed annually, or sooner if required, to ensure alignment with evolving strategic priorities and regulatory expectations. Quarterly progress updates will be provided to the Board.

How the action / information relates to achievement of strategic aims and objectives or improvement objectives

8. Leadership engagement in risk management is essential to achieving the Trust's strategic aims, including delivering safe care, developing high performing workforce, and ensuring sustainable services. The Risk Management Strategy and Framework 2025-28 establishes a robust governance structure that safeguards internal systems and embeds risk intelligence into planning, decision making and performance monitoring.
9. By linking operational risks to the Board Assurance Framework (BAF), it strengthens oversight, improves triangulation of data, and prevents misuse of the risk register. It supports transformation programmes, ICS wide priorities, and continuous improvement by enabling the Trust to anticipate and respond proactively to emerging risks.

Resource implications and how they will be met

10. Implementation will be supported through existing governance structures and resources. Training requirements identified through the Risk Management Training Needs Analysis can be delivered within current capacity. No additional funding has been identified at this stage, although future resource needs will be monitored as the framework matures.

11. Efficiency gains are expected through streamlined reporting, reduced duplication, and improve use of digital risk management systems. Any future resource implications will be brought back to the Board for consideration.

Benchmarking Intelligence

12. The Risk Management Strategy and Framework 2025-28 is aligned with nationally and internationally recognised best practice, incorporating key principles from HM Treasury's 'Orange Book', Health and Safety Executive (HSE) HSG 65 model for managing health and safety, NHS Resolution guidance and the Good Governance Institute (GGI). Crucially, it is informed by ISO 31000:2018 Risk Management Standards, providing a globally recognised foundation for a systematic, transparent, and effective approach to managing risk across all levels of the organisation.
13. Benchmarking against peer Trusts and ICS partners has informed the development of the framework, and ongoing benchmarking will be incorporated into annual reviews. Learning from national inquiries and reports has also shaped the approach to ensure the Trust meets modern expectations of governance maturity.

Conclusion of Report

14. Approval of the Risk Management Strategy and Framework 2025-28 is essential to ensuring a consistent, transparent and effective approach to managing risks across the organisation. The framework strengthens governance, aligns with national standards, and underpins the delivery of safe, personal and effective care.
15. It equips the Trust with the necessary tools and structures needed to proactively identify, assess, and mitigate risks, while embedding risk intelligence into strategic planning and operational decision making. Without formal Board approval, the Trust faces the risk of fragmented risk practices, diminished assurance on internal controls and potential non-compliance with regulatory expectations.

Recommendations

16. The Trust Board is asked to:
    a. Approve and ratify the Risk Management Strategy and Framework 2025-28.
    b. Endorse the implementation plan and monitoring arrangements, including quarterly updated to the Board.
    c. Delegate authority to the Audit and Risk Committee and Executive Lead for any minor amendments during or after implementation.

Next Actions

17. Following approval, the Risk Management Strategy and Framework 2025-28 will be communicated Trust wide through approved communication channels, leadership briefings and governance bulletins. Structured workshops, training and awareness programmes will be launched to support staff in applying the framework effectively
18. Additionally, it will be embedded into induction, professional development and existing committee reporting cycles. Related policies and procedures will be updated to ensure alignment with the new approach.

How the decision will be communicated internally and externally

19. Internal communication will be delivered through governance bulletins, the Trust intranet, divisional briefings, clinical governance meetings and safety huddles. Targeted communication will be provided to high-risk services and leadership groups.
20. Externally, the decision will be referenced in Board papers and, where appropriate, public facing documents, to promote transparency and strengthen stakeholder confidence, including ICS partners and commissioners.

How progress will be monitored

21. Progress will be monitored through established governance structures. The Audit and Risk Committee will undertake an annual review of the strategy's effectiveness, supported by internal audit and external assurance where appropriate.
22. In addition, the Executive Risk Assurance Group will provide regular oversight, tracking implementation progress and ensuring risks are appropriately managed. The Risk Assurance Meeting and Trust Wide Quality Governance meeting will conduct routine reviews to assess compliance, performance and alignment with strategic objectives. A maturity assessment will be used to track progress over the three-year period.

Mr J Houlihan - Assistant Director of Health, Safety and Risk

31 December 2025

East Lancashire Hospitals NHS Trust
A University Teaching Trust

TRUST WIDE DOCUMENT

Delete as appropriate	Policy
DOCUMENT TITLE	Risk Management Strategy (Framework, Policy and Procedure) 2025-28
DOCUMENT NUMBER:	ELHT C002 V13.1
DOCUMENT REPLACES Which Version	ELHT C002 V12.1 Risk Management Framework (Strategy, Policy and Procedure) 2021-24
LEAD EXECUTIVE DIRECTOR DGM	Executive Medical Director
AUTHOR(S):Note should <u>not</u> include names	Assistant Director of Health, Safety and Risk Management
TARGET AUDIENCE:	Trust Wide
DOCUMENT PURPOSE:	This document outlines the commitment of East Lancashire Hospitals NHS Trust to effective risk management and provides a comprehensive framework for the identification, assessment, management, control and review of risks to ensure the delivery of safe, personal and effective care and the quality, safety and efficiency of services.

To be read in conjunction with (identify which documents)	• Clinical Strategy • People Plan • Quality Strategy • Resourcing Strategies (Estates/Digital/Finance) • Health and Safety Strategy and Framework • Patient Safety Incident Response Framework • Board Assurance Framework • ELHT Risk Appetite Statement • Health and Safety at Work Policy • Incident Management Policy • Emergency Planning, Response and Resilience Policy • Infection Prevention and Control Policy • Medical Devices Management Policy • Medicines Management Policy • Fraud, Bribery and Corruption Policy • Standing Orders, Standing Financial Instructions and Scheme of Delegation
Supporting References	• The Health and Safety at Work etc. Act 1974 • Management of Health and Safety at Work Regulations 1999 • Health and Safety (Training for Employment) Regulations 1990 • Health and Safety (Information for Employees) Regulations 1989 • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Health and Safety Executive Guidance HSG 65 '*managing for health and safety*' • Care Quality Commission '*fundamental standards of quality and safety*' Further guidance on risk management can be obtained from the following national bodies: • Care Quality Commission England • Good Governance Institute • Health and Safety Executive • Health Education England • HM Treasury 'Orange Book' • Institute of Occupational Safety and Health • Institute of Risk Management • Medicines and Healthcare Products Regulatory Agency • NHS Providers • NHS Resolution

CONSULTATION		
	Committee/Group	**Date**
Consultation	Risk Assurance Meeting	Feb-25
	Trust Wide Quality Governance Group	Mar-25
	Quality Committee	Apr-25
	Executive Team Meeting	Jul-25
Approval Committee	Audit Committee	Oct-25
Board Ratification:	January 2026	
NEXT REVIEW DATE:	January 2028	
AMENDMENTS:	The risk management strategy has been redefined to better support key elements of the framework and policy, in particular, more specific arrangements and responsibilities of key staff groups in relation to the identification, assessment, management, control and review of risks and strengthening of risk governance to enhance risk management accountability, oversight and performance and assurances of the robustness of internal systems and controls.	

Contents

1. Introduction

1.1. Risk management is a critical component of effective healthcare service delivery within the NHS. It involves the identification, assessment and mitigation of threats and vulnerabilities that could negatively impact on the quality and delivery of service provision.

1.2. By embracing a proactive and systematic approach, NHS organisations can minimise the likelihood of adverse events, protect its patients and staff, ensure organisational efficiency and maximise opportunities and outcomes.

2. Rationale

2.1. The Risk Management Strategy (Framework, Policy and Procedure) describes the process for implementing the requirements of the Corporate Manslaughter and Corporate Homicide Act 2007, the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and of all other associated Approved Codes of Practice, Regulatory Standards and Guidance relating to the safeguard and protection of patients, staff and others, from risks associated with the undertaking of work activities and use of assets.

3. Purpose

3.1. This document outlines the commitment of East Lancashire Hospitals NHS Trust, referred to hereafter as 'the Trust', to effective risk management. It provides a comprehensive framework for managing risks within the Trust to ensure the delivery of safe, personal and effective care and the quality, safety and efficiency of services.

4. Scope

4.1. All staff, and others, directly or indirectly employed by, or working within, the Trust are expected to cooperate with the requirements of this framework and any associated policies and or procedures.

4.2. It applies across all services and covers all aspects of healthcare service delivery including clinical care, corporate and operational activities and strategic planning.

5. Principles

5.1. The commitment underpinned within the risk management statement of purpose contained within these appendices reflects the basic principles of risk management in that**:**

a) Risk management activities must be **proportionate** to the level of risk faced by the Trust.

b) Risk management activities need to be **aligned** with other activities in the Trust.

c) Risk management approach must be **comprehensive** to be fully effective.

d) Risk management activities need to be fully **embedded** within the Trust.

e) Risk management activities must be **dynamic and responsive** to emerging and changing risks.

6. The Importance of Risk Management

6.1. The management of risks is a statutory legislative requirement and fundamental health and safety principle that remains highly integral to the effectiveness of any organisational safety management system.

6.2. It is a key line of enquiry used by regulatory bodies such as the Care Quality Commission, Health and Safety Executive etc. when conducting visits or inspections and monitoring quality and safety standards and healthcare service provision.

6.3. Whilst good risk management seeks to eliminate or minimise threats and maximise opportunity, it requires a pragmatic and systematic, not frivolous, approach.

7. Benefits of Good Risk Management

7.1. The benefits of good risk management are that it:

a) Protects patients, staff and the organisation from harm.

b) Minimises loss.

c) Ensures compliance with legal, regulatory and accreditation requirements.

d) Helps maintain license to operate requirements.

e) Facilitates strategic and operational planning.

f) Enhances decision making.

g) Improves organisational resilience.

h) Optimises use and allocation of resource.

i) Improves organisational efficiency and drives innovation.

j) Reduces financial, legal and insurance costs.

k) Enhances stakeholder confidence.

l) Improves organisational credibility, reputation and commercial viability.

8. Risk Management Strategy

8.1. Key elements of the risk management strategy are to:

a) Define the risk management framework.

b) Identify potential threats and vulnerabilities which impact on strategy, goals and objectives.

c) Develop risk mitigation strategies and treatment plans.

d) Establish suitable risk management controls.

e) Monitor and review risks on a continuous, ongoing basis.

f) Consider new and emerging risks.

g) Develop and implement a communication plan to inform stakeholders of risk activity and decision making.

h) Foster awareness and support for risk management initiatives.

9. Risk Management Framework

9.1. The risk management strategy is supported by a risk management framework. Key elements of the risk management framework include:

a) A structured approach and consistent process to managing risks.

b) The Board having ultimate responsibility for risk management and risk appetite.

c) The use of risk identification tools, techniques and methodology.

d) Evaluation of the likelihood and impact of identified risks using qualitative and quantitative risk assessment methods.

e) Developing and implementing risk treatment plans to address risks by way of their avoidance, reduction, transfer, acceptance or diversification.

f) Establishing clear roles, responsibilities and decision-making processes for effective risk governance.

g) Effective use of risk management software to improve logging of risks, tracking and reporting.

h) Risk management policy and or procedures.

i) Robust incident reporting and investigation processes.

j) Education, training and competency needs and programmes.

10. Procedure

10.1. A list of associated documents that should be read in conjunction with this framework is included within the document control page.

11. Policy Development

11.1. Members of the Risk Assurance Meeting (RAM), Executive Risk Assurance Group (ERAG), Trust Wide Quality Governance Meeting (TWQGM), Quality Committee and Audit and Risk Committee have been consulted on the requirements of this strategy and framework.

12. Roles, Responsibilities and Duties

12.1. Generic Statement

a) Staff identified as having a key role within this strategy and framework, and any associated policies and or procedures, will be asked to provide evidence to support their specific role through one to one, appraisal and or behavioural frameworks.

12.2. The Chief Executive Officer is responsible for:

a) Holding ultimate responsibility for risk management, ensuring compliance, strategic alignment and accountability to the Board.

b) Establishing a proactive risk aware mindset, fostering transparency, stakeholder collaboration and continuous organisational learning.

c) Ensuring the availability of essential tools, training and governance frameworks to effectively address clinical, operational and emerging risks.

d) Directing crisis response, business continuity planning and adaptive strategies that safeguard long-term organisational stability.

12.3. **The Trust Board are responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Providing strategic direction and guiding the development and implementation of risk management initiatives, effective risk mitigation strategies and risk improvement recommendations.

c) Overseeing the implementation of the risk management strategy and or operating framework and internal controls.

d) Setting and reviewing risk appetite statements, defining levels of risk the Trust is willing to accept in pursuit of its strategic and operational objectives and formalising risk acceptance and its boundaries.

e) Managing the organisation in a crisis and understanding and enacting upon the most catastrophic and or significant risks.

f) Reviewing and approving regular reports on key areas of risk, mitigations and performance and any significant changes, taking corrective risk treatment action, where required.

12.4. **Senior Executives and Directors are responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Establishing the structure for risk management and providing the resource, governance and oversight to support the risk management process and activities.

c) Approving the risk management strategy and or operating framework and ensuring its implementation.

d) Creating and executing plans to manage identified risks and their alignment with strategic objectives, tracking the effectiveness of risk mitigation strategies and identifying new and emerging risks.

e) Ensuring cohesive and uniformed addressing of all identified risks within their areas of responsibility and control and seeking assurances that such risks are suitably mitigated.

f) Establishing clear roles, responsibilities and decision-making processes for effective risk management governance to enhance accountability and oversight.

g) Monitoring and reviewing risks approved onto the corporate risk register, ensuring they are suitably managed and mitigated, with appropriate risk treatment plans in place.

h) Reviewing and approving regular reports on key areas of risk, mitigations and performance and any significant changes, taking corrective risk treatment action, where required.

i) Fostering a culture of trust, transparency and accountability for risk management and communicating, educating and motivating all stakeholders to support the risk management process.

12.5. **The Assistant Director of Health, Safety and Risk is responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Acting as the named 'competent' person for health, safety and risk management, as required, and in accordance with statutory legislation.

c) Providing strategic direction and professional, expert advice and guidance on good risk management principles, practice and applied methodology, setting priorities for future action.

d) Developing, implementing and maintaining an effective risk management strategy, policy and or operating framework and ensuring they are regularly reviewed and updated.

e) Ensuring cohesive and uniformed addressing of all identified risks and of seeking assurance from risk owners that such risks are suitably mitigated.

f) Overseeing the implementation of effective risk management software and its use to support risk identification accuracy and improve logging of risks, tracking and reporting.

g) Setting risk management key performance targets and monitoring performance, tracking the effectiveness of risk mitigation strategies and identifying new and emerging risks.

h) Monitoring and evaluating the effectiveness and integrity of risk management systems, internal controls and processes and that risk exemptions in strategy, policy and or operating framework are reported and escalated through relevant risk governance functions.

i) Identifying risk management training needs and that relevant staff are equipped with the necessary knowledge and skills to identify, assess and manage identified risks effectively within their respective roles.

j) Establishing and maintaining collaborative relationships with key stakeholders, including senior management, heads of service and external partners to ensure effective risk management across the Trust.

12.6. **All Identified Risk Owners are responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Assisting in fulfilling the requirements of this strategy and framework and any other associated policies and or procedures.

c) Identifying and managing risks within their areas of responsibility and control.

d) Assessing the likelihood and impact of identified risks using approved risk management methodology.

e) Developing and implementing suitable and sufficient risk mitigation strategies and treatment plans for identified risks specific to their area.

f) Using approved risk appetite statements in their response to any actions and ability to accept and manage risks.

g) Clearly articulating identified risks, actions and treatment plans on the risk register and using relevant proformas, where necessary.

h) Collaborating with heads of service, managers, matrons and divisional quality and safety leads to identify, assess and inform effective application regarding the management of risks within their specialty.

i) Monitoring and reviewing risk performance across services, tracking the effectiveness of control measures introduced e.g. policy and procedural implementation and arrangements, internal management and auditing systems etc.

j) Regularly updating controls, assurances and risk scores for all identified risks on the risk register, in a timely manner and in accordance with agreed risk review cycles.

k) Reporting identified risks, and their escalation and treatment, through risk governance processes, where required.

l) Engaging and providing timely feedback to individuals, committees or groups to ensure the effectiveness of this framework and any associated policies and or procedures.

m) Ensuring they have received suitable and sufficient information, instruction, training and or supervision and are competently equipped with the knowledge and skills to perform risk management activities and controls, where required.

n) Seeking assurances appropriate actions are taken for agency, contractor, service level agreement providers and others, and that measures following the management of risks and outcome of risk assessments are shared with their employers and reviewed and enacted upon in a timely manner.

12.7. **Heads of Service, Managers, Matrons and Divisional Quality and Safety Leads are responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Ensuring that they, and staff whom they are responsible for, understand, are aware of, and adhere to the requirements of this strategy and framework and any associated policies and or procedures.

c) The onward cascade of this framework and any associated policies, procedures, guidance or amendments, to such staff, via approved communication and consultation methods, and that this is documented.

d) Being aware of risks associated with their role, tasks and the work environment and how they are assessed and managed.

e) Working collaboratively with risk owners and ensuring all identified risks are being assessed, prioritised and managed within their respective services.

f) Implementing risk management practices within their services. This includes the use and conducting of risk assessments, identifying when an assessment review or further action is required.

g) Seeking advice, where necessary, from risk owners and or competent persons should a significant risk be identified, with such risks either removed or exposure avoided, where practicable.

h) Monitoring and keeping records of all risk assessments performed and any accompanying documentation and that they are made readily available, where necessary.

i) Communicating risk information and findings of risk assessments to all relevant staff and stakeholders, informing team members of potential risks and their mitigation.

j) Making sure staff and others, within their areas of responsibility, comply with any safe systems or suitable control measures introduced to eliminate or reduce risks to their lowest level practicable.

k) Monitoring and reviewing departmental risk management performance across services, tracking the effectiveness of control measures introduced e.g. policy and procedural implementation and arrangements, internal management and auditing systems etc.

l) Engaging and providing timely feedback to individuals, committees or groups to ensure the effectiveness of this framework and any associated policies and or procedures.

m) Ensuring they have received suitable and sufficient information, instruction, training and or supervision and are competently equipped with the knowledge and skills to perform risk management activities and controls, where required.

n) Being aware of and enacting upon those staff, and others, within their areas of responsibility and control, who do not adhere to the requirements of this strategy and framework, and any associated policies and or procedures, using human resources intervention and staff behavioural frameworks, as required.

12.8. **The Health, Safety and Risk Manager is responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Providing professional, expert advice and guidance on good risk management principles, practice and applied methodology.

c) Managing the risk identification, assessment, mitigation, monitoring and reporting process and supporting risk management system.

d) Ensuring the integrity of risk assessments, using appropriate methodologies, to evaluate the likelihood and impact of each identified risk.

e) Implementing and maintaining effective application of risk management software, effective use of the risk register and risk management process in documenting risk identification and mitigation accuracy.

f) Supporting the development and implementation of risk mitigation strategies, including preventative and corrective actions.

g) Analysing risk data to identify trends and patterns and improve logging and tracking of risks.

h) Monitoring risk management key performance indicators and targets.

i) Tracking and monitoring the effectiveness of risk management activities and risk mitigation strategies of all identified risks.

j) Preparing and presenting regular reports on the status of risk management activities, culture and performance.

k) Communicating risk information effectively to relevant stakeholders.

l) Identifying and supporting risk management education, training and development opportunities that includes coaching and mentoring of managers and staff with responsibility for managing risks.

m) Fostering a culture of risk awareness and accountability.

12.9. **The Datix Manager is responsible for:**

a) Demonstrating visible leadership, by example, of practicing safe risk prevention methods and of promoting and influencing a positive, effective risk intelligence culture and its integration into all organisational activities.

b) Managing the configuration, integrity, maintenance, availability and security of the Datix system, the software platform used for incident reporting and risk management.

c) Making system enhancements to Datix risk management software for better tracking and performance.

d) Developing and maintaining risk management dashboards for visualising key risk management performance metrics.

e) The review and implementation of Datix system upgrades and patches.

f) Providing suitable and sufficient information, instruction, training and or supervision to identified users on the Datix incident and risk management reporting modules.

g) Fostering a culture of risk awareness and accountability.

12.10. **All Staff are responsible for:**

a) Ensuring they understand, are aware of, and adhere to the requirements of this strategy and framework and any associated policies and or procedures.

b) Being aware of risks associated with their role, tasks and the work environment and how they are assessed and managed.

c) Observing, understanding and carrying out guidance in relation to the management of risks, where provided.

d) Actively participating in the risk management process by reporting all potential risks to the risk owner and or their line manager in a timely manner using approved and established communication and consultation systems.

e) Cooperating with risk mitigation measures in relation to the investigation of accidents and incidents and outcomes of risk assessments etc.

f) Acknowledging agreement and compliance with any special arrangements, safe systems, measures, improvements or changes introduced to eliminate or reduce identified risks to their lowest level practicable.

g) Participating in risk management initiatives, where necessary, and providing feedback to improve the risk management process.

12.11. **All Agency, Contractor, Service Level Agreement Providers and Others are responsible for:**

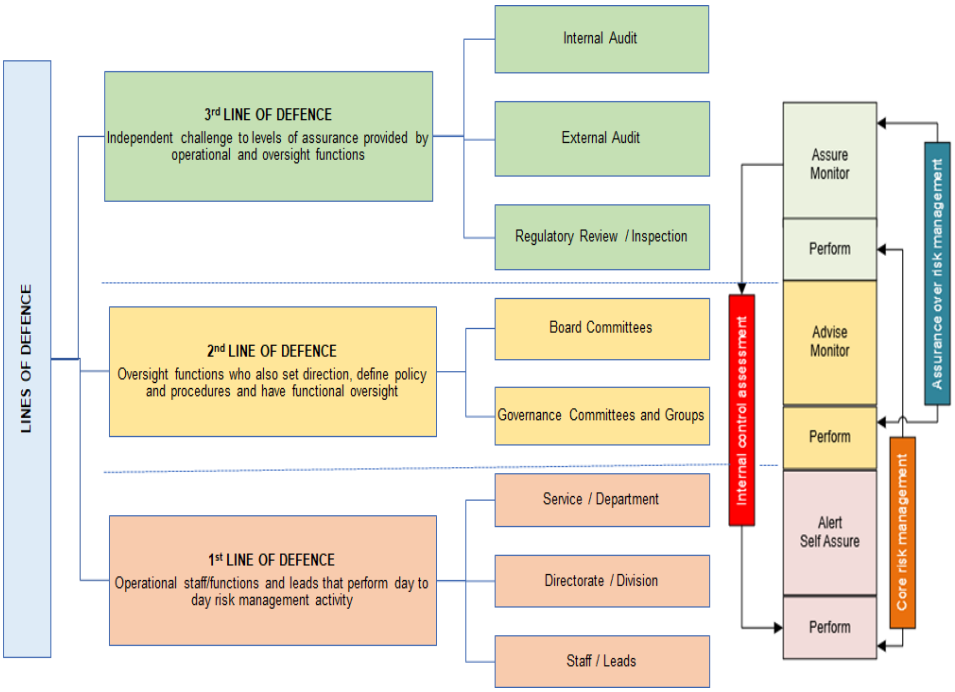
a) Ensuring they understand, and are aware of, their legal and moral responsibilities relating to the management of risks within their areas of responsibility and control and are fully committed to working to eliminate and or reduce risks to their lowest level practicable, as well as minimising the impact upon the environment.

b) Assisting in fulfilling the requirements of this strategy and framework and any other associated policies and or procedures.

13. Risk Governance

13.1. Risk governance is often referred to as the institutions, rule conventions, processes and mechanisms by which decisions about risks are taken and implemented.

13.2. The Trust uses the recognised 'three lines of defence' model, illustrated in the diagram below, in seeking assurance that risks are being suitably managed. This model also applies to the Board Assurance Framework.



13.3. Risk governance provides a framework that includes clear roles and responsibilities of committees, sub committees and groups in relation to overseeing and managing risks effectively. These generic responsibilities include:

a) Managing risks in specialist areas of responsibility and control.

b) Establishing and implementing risk treatment plans.

c) Developing specialist contingency and recovery plans.

d) Keeping up to date with developments within their specialist fields.

e) Supporting the investigation of accidents, incidents and near misses and thematic reviews.

f) Monitoring and reviewing risk performance and compliance across services.

g) Liaising with other committees, sub committees, groups and services to ensure risks are managed in a holistic and integrated way.

h) Seeking assurances regarding the effectiveness of internal management systems and controls e.g. policy and procedural implementation and arrangements, completion and review of risk assessments etc.

i) Supporting continuous improvement of the risk management operating framework and process.

13.4. In support of the above generic responsibilities, a summary of the roles of Committees and or Groups in relation to risk governance across the Trust is included below:

a) **The Audit and Risk Committee** is responsible for providing assurances to the Board of risk management effectiveness and of robust scrutiny and challenge on key elements of the risk management strategy and framework, internal systems and controls.

b) **The Finance and Performance Committee** is responsible for having oversight of the management of key areas of identified financial type risks and providing assurances to the Board on the systems of internal control and their effectiveness in mitigating them. It includes the scrutiny of financial plans, revenue and capital budgets, investment decisions, contract management and procurement, national and local performance activity and transformation schemes.

c) **The Quality Committee** is responsible for having oversight of the management of strategic risks and providing assurances to the Board of risk governance effectiveness and of robust scrutiny and challenge on key elements of risks on the board assurance framework, internal systems and controls.

d) **The People and Culture Committee** is responsible for having oversight of the management of key areas of identified human resources type risks and providing assurances to the Board on systems of internal control and their effectiveness in mitigating them.

e) **The Trust Wide Quality Governance Meeting** is responsible for having oversight of internal governance systems and controls and of providing assurances through to the Board on risk governance effectiveness.

f) **The Executive Risk Assurance Group** is responsible for scrutinising and approving high or extreme risks scoring fifteen or above onto the 'corporate' risk register for board level monitoring and review, overseeing the management of risks held on the 'corporate' risk register and supporting effective delivery of the risk management strategy and framework.

g) **The Risk Assurance Meeting** is responsible for ensuring risks presented as being high or extreme risks scoring fifteen or above are robustly scrutinised in line with the risk scoring criteria and, where necessary, recommended for approval to the Executive Risk Assurance Group, reviewing the quality of risks held on the risk register and ensuring they are effectively and robustly reviewed, managed and monitored.

h) **The Clinical Effectiveness Group** is responsible for having oversight of the management of key areas of identified clinical type risks i.e. medical, nursing and management, and providing assurances through to the Board on systems of internal control and their effectiveness in mitigating them.

i) **The Data and Digital Committee** is responsible for having oversight of the management of key areas of identified data and digital type risks and providing assurances through to the Board on systems of internal control and their effectiveness in mitigating them.

j) **The Emergency Planning, Response and Resilience Committee** is responsible for having oversight of the management of identified emergency planning, response and resilience type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

k) **The Health and Safety Committee** is responsible for having oversight of the management of key areas of identified health and safety type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

l) **The Infection, Prevention and Control Committee** is responsible for having oversight of the management of key areas of identified infection prevention and control type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

m) **The Medical Devices Steering Committee** is responsible for having oversight of the management of key areas of identified medical devices type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

n) **The Medicines Safety and Optimisation Committee** is responsible for having oversight of the management of key areas of identified medicines management type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

o) **The Patient Safety Group** is responsible for having oversight of the management of key areas of identified patient safety type risks and providing assurances through to the Board on systems of internal control and performance against set standards and their effectiveness in mitigating them.

p) **Divisional Quality and Safety Boards** are responsible for implementing risk management practices within their services which includes regular review of localised risks, completion of risk assessments, monitoring and reviewing risk management performance and liaising with identified risk owners, Committees and or Group in ensuring all matters relating to the management of risks are considered in a holistic and integrated way.

14. Risk Management Process Overview

14.1. Process Overview

a) The Trust follows a structured approach to risk management to ensure risks are suitably identified, assessed, managed, controlled and reviewed effectively.

b) The key steps involved in the risk management process are summarised below:

- **Risk identification** involves the identification of potential threats and vulnerabilities that impact on the Trust's activities and objectives

- **Risk analysis** involves all identified risks being assessed in terms of their impact, likelihood and actual or potential consequence

- **Risk mitigation** involves the development of plans to determine which risks require immediate attention based on significance and, through supporting risk appetite statements, the introduction of specific controls and risk treatment plans that seek to eliminate risks or reduce them to as low as is reasonably practicable

- **Risk treatment** involves the measures introduced to avoid, accept / tolerate, reduce, transfer or diversify risks ensuring they are being managed effectively and suitably controlled

- **Risk monitoring** involves the review of risks on a continuous, ongoing basis to ensure that control measures introduced remain suitable and sufficient

c) A more comprehensive and detailed application of the risk management process is contained within the appendices.

15. Risk Appetite

15.1. Risk appetite is the key to achieving effective risk management and of balancing benefits and opportunities with potential threats and remains central to any risk management strategy and overarching organisational strategy.

15.2. The Trust has adopted guidance, referred to within the document control page, which helps the Board to define the amount and type of risk it is prepared to pursue, retain or take in pursuit of its strategic objectives.

15.3. The Board has developed its risk appetite statements which form part of the Trust's overall risk management strategy and framework and guides risk owners in their actions and ability to manage risks.

15.4. The following risk appetite scales broadly show the different appetite levels that may need to be taken to achieve strategic objectives:

a) **Averse (None)** i.e. avoidance of risk and uncertainty is a key objective.

b) **Minimal (Low)** i.e. preference for safe options that have a low degree of risk or reward.

c) **Cautious (Moderate)** i.e. preference for safe options that have a moderate degree of risk or reward.

d) **Open (High)** i.e. a willingness to consider all treatment options and choose one that is most likely to result in successful delivery or reward.

e) **Pursue (Significant)** i.e. a willingness to be innovative and to choose options that suspend previous held assumptions and accept greater uncertainty.

15.5. The risk appetite statement is reviewed at least annually by the Board or where there is reason to suspect its validity.

15.6. The Trust's risk appetite statements are included within the appendices, providing detailed reference to its approach to risk tolerance and management.

16. Board Assurance Framework

16.1. The Board Assurance Framework refers to the wider systems and processes of governance which are in place that provides the Board with assurance regarding the achievement of its strategic objectives.

16.2. It is a high-level document and key source of evidence that links strategic objectives to operational risks and assurances and is the main tool that the Board uses to discharge its overall responsibility for internal control.

16.3. The Trust has established a Board Assurance Framework that is reviewed by nominated Executive Directors and their deputies. It includes:

a) Risk reporting i.e. regular reporting on key strategic risks, their mitigation and performance.

b) Risk governance i.e. the use of dedicated committees, sub-committees and groups to provide expert advice and support on risk mitigation, use of dashboards and key performance indicators etc.

c) Risk review i.e. annual reporting, periodic audits and review of risk management, including the effectiveness of internal systems, processes and controls.

d) Board approval i.e. review of the risk register and the formal approval and review of risk appetite statements, risk management policy and key risk mitigation plans.

16.4. Risks are linked to a number of strategic aims and objectives which include:

a) **Strategic risks** i.e. risks that affect the Trust's ability to deliver its strategy or function as an organisation.

b) **Financial risks** i.e. risks relating to revenue, expenses or financial performance.

c) **Operational risks** i.e. risks that affect the delivery of business plans or common risks requiring a corporate response.

d) **Local risks** i.e. risks relating specifically to departmental or service operations and objectives.

e) **Project or programme risks** i.e. risks associated with time limited activities and short to long term delivery of benefits.

17. Risk Register

17.1. A risk register is a central repository of risks that helps track the ownership, assessment and management of identified risks consistently and systematically.

17.2. It is a dynamic living document that is populated through the risk identification, analysis and mitigation process which enables risks to be quantified and scored.

17.3. The overall aim of the risk register is not to document all the risks faced by the Trust e.g. insignificant and or minor risks, but more those risks identified as being moderate to catastrophic and to record the action or treatment plans to mitigate those risks to acceptable levels.

17.4. The effective use of the risk register provides a structure for owners of identified risks to collate information about the types of risks that helps with their analysis and in decisions about whether or how those risks should be treated.

17.5. In addition, the risk register can also support the development of strategic plans, the prioritisation of risks and mitigations, allocation of resources and reports on progress.

17.6. A risk register is not always necessary or appropriate and should only be used by owners of identified risk types and sub type categories. It is not to be used frivolously by staff and or for personal, political or financial gain.

17.7. When used correctly, the risk register can help demonstrate an effective risk management approach is in place that avoids duplication, improves standardisation and the quality and quantity of risks held, how they are owned and managed.

17.8. To avoid confusion and prevent misuse of the risk register:

a) Incidents and issues are things that have already happened, were not planned, require management action and need to be reported and investigated in line with the incident management policy.

b) Risks are things that may happen that prevent the achievement of organisational objectives or otherwise impact on its success.

17.9. The Trust maintains a comprehensive risk register by way of using the Datix risk management module, documenting all identified risks, their ratings, mitigation strategies and assigned owners.

17.10. Minimum descriptors of the risk register are contained within the appendices.

18. Risk Acceptance

18.1. The Trust has risk appetite statements, referred to within the previous section, which define the levels of risk it is willing to accept or tolerate despite their potential negative consequence.

18.2. The decision to accept a risk is usually made after careful assessment of the likelihood and consequence of the risk and determination as to whether the cost of mitigating the risk outweighs the potential benefits.

18.3. The use of risk treatment options, contained within the appendices, are required to be used by risk owners when determining whether a risk is accepted or not.

18.4. A number of key factors for consideration by risk owners when determining risk acceptance include the following:

a) The low likelihood of risk i.e. the risk is unlikely to occur.

b) The low consequence of risk i.e. negligible or low risk outcomes that even if the risk materialises, its impact is deemed to be manageable.

c) A cost benefit analysis i.e. the cost of mitigating the risk is considered too high compared to the favourable benefits.

d) Strategic considerations i.e. accepting the risk might be better aligned with strategic objectives.

18.5. When accepting risks, it is important that risk owners remain transparent and communicate them to relevant stakeholders, outlining the rationale behind the decision.

18.6. Acceptable risks are still required to be actively monitored to ensure the risk remains valid and or has not escalated beyond any acceptable threshold.

18.7. Whilst accepting the risk, contingency plans need to be in place to respond effectively should any risk materialise.

19. Risk Closure

19.1. When an overall risk rating score remains insignificant and or minor and continues to be well managed, controlled and documented, the risk can be closed and removed from the risk register.

19.2. If a target score has been met, however, there is still a degree of risk remaining i.e. the risk cannot be eliminated or reduced to as low as is reasonably practicable because there are no further controls or assurances to prevent it, reducing it further would introduce far greater risks or it would be grossly disproportionate to control it, the risk can be become accepted, providing it has been approved at a relevant Committee or Group responsible for overseeing the risk and it continues to be periodically reviewed in line with any risk review cycles.

19.3. If the risk still has several actions that require completion or gaps in controls and assurances, the risk needs to remain as being a live risk until the above conditions are met. This may involve the risk owner reviewing the robustness of internal systems of control and assurance and where necessary, rescoring the risk, possibly higher, and revisiting risk treatment options.

20. Internal Audit

20.1. It is the role of an internal auditor to provide an opinion to the Trust Board on assurances on the effectiveness of its risk management internal systems, operating controls and the Board Assurance Framework. The Mersey Internal Audit Agency is the internal audit provider for the Trust.

21. External Audit

21.1. In addition to internal audits, the Trust looks to relevant external bodies such as the Health and Safety Executive, Care Quality Commission, Medicines and Healthcare Products Regulatory Agency and NHS Resolution, to name but a few, in assisting to progress its risk maturity, capability and performance.

22. Policy Dissemination

22.1. This strategy and framework, and any associated policies and or procedures, will be disseminated via Trust approved communication and consultation mechanisms.

23. Implementation

23.1. It is anticipated good risk management principles, along with a proactive risk intelligence culture, will have a positive enabling effect in improving the working lives of all staff through collaborative, compassionate and inclusive leadership and reduced likelihood of risk (The NHS Long Term Plan and NHS People Plan).

24. Monitoring Compliance and Key Performance Indicators

24.1. Regular monitoring of compliance and performance against this strategy and framework is undertaken by those aforementioned Committees and or Groups.

24.2. Where deficiencies have been identified, action and risk treatment plans will be developed and monitored, along with the escalation of risk exceptions, to the Board and its Committees on a regular basis.

24.3. Set key performance indicators are used to measure risk management activity and track progress towards achieving risk management objectives and are measured through a variety of metrics.

24.4. In addition, the following table, shown overleaf, outlines the minimum requirements for monitoring compliance with this framework.

Aspect of compliance being measured or monitored	Individual responsible for the monitoring	Tool and method of monitoring	Frequency of monitoring	Responsible Committee or Group for monitoring
Strategy and Framework	Assistant Director of Health, Safety and Risk	Regular review and report	Annually or where there is reason to suspect its validity	Audit Committee Trust Wide Quality Governance Group Executive Risk Assurance Group
Policy arrangements	Assistant Director of Health, Safety and Risk	Regular review and report	Annually or where there is reason to suspect its validity	Audit Committee Trust Wide Quality Governance Group Executive Risk Assurance Group
Risk management systems and processes	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Quality Committee Trust Wide Quality Governance Group Health and Safety Committee
Communication and engagement	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Trust Wide Quality Governance Group Executive Risk Assurance Group Risk Assurance Meeting
Education, training and competency	Health, Safety and Risk Manager	Regular review and report	Annually or where there is reason to suspect its validity	Audit Committee Trust Wide Quality Governance Group Executive Risk Assurance Group

25. Education, Training and Competency

25.1. The Trust has set out its education, training and competency requirements within its risk management training needs analysis, included within these appendices, which aims to ensure groups of staff having significant risk management responsibilities are equipped with the necessary knowledge and skills to identify and enact upon risks effectively and competently within their respective roles.

25.2. All staff have an appraisal and personal development review to identify individual training and development needs.

25.3. In support of the risk management process, suitable and sufficient information, instruction and or training is also provided, where necessary, to identified users on the use of the Datix system, the software platform used for incident and risk management.

25.4. Additional and or supplementary training, including coaching and mentoring, is in accordance with the training needs analysis and or any risk or safety management outcomes and will be continuously reviewed, and, where necessary, updated when major changes or activities occur.

26. Communication and Engagement

26.1. Effective communication and engagement are essential for successful risk management. The Trust will ensure it:

a) Continues to promote a culture of risk awareness.

b) Encourages staff to suitably identify and report potential risks.

c) Shares relevant risk information with stakeholders in a timely and transparent manner.

d) Involves stakeholders in risk management activities, seeking their input and feedback.

27. Archiving Arrangements

27.1. All policies and or procedures are archived in compliance with the Trust Records Retention Policy.

28. References

28.1. This strategy and framework should be read in conjunction with those internal documents identified within the document control page.

29. Associated Documents

29.1. A list of primary and secondary legislation and further guidance can be found within the document control page.

Appendix A Risk Management Statement of Purpose

East Lancashire Hospitals NHS Trust is committed to providing safe, personal and effective care and high-quality service provision. To achieve this, we recognise the importance of having a robust risk management strategy and framework and of proactively identifying, understanding and managing risks inherent to our services and future plans to encourage responsible and informed risk taking and of maximising opportunity.

We accept the need to take proportionate risks to achieve our strategic objectives but expect these to be appropriately identified, assessed and managed. Through managing risks and opportunities in a structured manner, we will maintain a stronger position to ensure we meet our objectives.

As a responsible healthcare service provider and employer our risk management approach aims to:

- Be person centred i.e. all risk management decisions and actions are guided by the needs and safety of our staff and patients.
- Promote a proactive and systematic approach to managing risks by way of risks being identified, assessed, managed and reviewed proactively, minimising the likelihood of adverse events.
- Be proportionate and reflect the size, shape and nature of the organisation.
- Ensure risk management is an integral part of organisational planning and decision making.
- Enable us to deliver our priorities and services economically, efficiently and effectively.
- Align risk management and performance to drive improvements and better outcomes.
- Guard against impropriety, malpractice, waste and poor value for money.
- Assist compliance with legislation and set regulatory standards, such as that covering clinical practice, the environment, health and safety, employment practices and equalities.
- Ensure risk information is communicated in an open, transparent manner with accountability for risk management clearly defined.
- Continuously review and improve risk management systems and processes based on lessons learned and best practice.
- Minimise the prospects of any damage to the Trust's reputation and or undermining of public confidence.

All identified risks are required to be recorded with a core minimum amount of information, be assessed on the likelihood of risk and level of impact and have an identified risk owner.

The Board intend to use the risk management processes outlined within this framework as a means to achieve the aims set out within its strategy and objectives.

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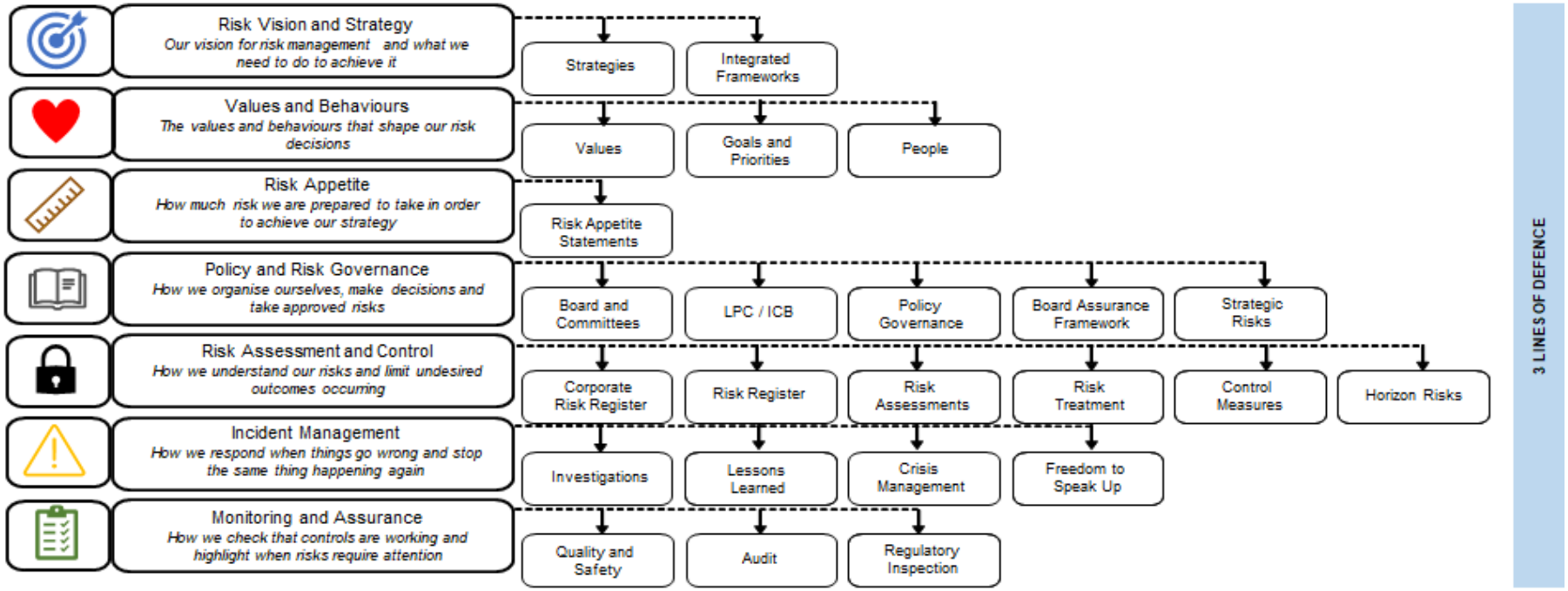
Chair	Chief Executive

Appendix B Risk Management Strategy and Framework on a Page



***LPC - Lancashire and South Cumbria Provider Collaborative**

***ICB – Integrated Care Board**

Appendix C Risk Types, Descriptors and Governance Assurance

The Trust has identified its risk types which are the principal risks which arise from the nature of the Trust's operating environment, supported by a comprehensive set of risk sub types aligned to each risk type and determined using risk management identification and methodology.

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by	Board Assurance Group
	Clinical	Potential for harm to patients due to inadequate clinical management systems and errors in diagnosis, treatment or care	Executive Medical Director / Chief Nurse	Deputy Chief Nurses / Deputy Medical Director	Identified Clinical Leads	Clinical Effectiveness Group	Quality Committee
	Data and Digital	Risks associated with the use, storage and transmission of data and reliability of digital systems	Executive Director of Finance	Chief Information Officr	Identified Data and Digital Leads	Data and Digital Committee	Finance and Performance Committee
	Emergency Planning	Threats in the ability to maintain service provision during, as well as after, significant failures of systems and of responding effectively to emergencies and natural disasters	Executive Director of Integrated Care, Partnerships and Resilience	Deputy Director of Integrated Care, Partnerships and Resilience	Emergency Preparedness, Planning and Resilience Manager	Emergency Preparedness, Planning and Resilience Committee	Finance and Performance Committee
	Financial	Risks of direct or indirect loss in relation to the Trust's financial stability such as budget deficits, financial reporting, fraud and inadequate revenue	Executive Director of Finance	Chief Management Accountant	Identified Finance Leads and Specialisms	Finance Oversight Group	Finance and Performance Committee
	Clinical Governance	Risks relating to the effectiveness of its registration, leadership, decision making, compliance with regulations and operation of its governance framework	Executive Medical Director	Associate Director of Quality and Safety	Identified Governance Leads and Specialisms	Trust Wide Quality Governance	Quality Committee
	Health and Safety	Risks relating to the health and safety of its staff, patients, visitors, contractors, buildings, assets and the environment	Executive Director of Integrated Care, Partnerships and Resilience	Assistant Director of Health, Safety and Risk	Identified Safety Leads and Specialisms	Health and Safety Committee	Quality Committee

	Risk Type	Summary Descriptor	Exec Lead	Senior Leadership Support	Management of Risk Sub Types	Oversight by	Board Assurance Group
	Human Resources	Risks relating to workforce supply, recruitment and retention, skills and competency, behaviours and performance, wellbeing and culture	Executive Director of People and Culture	Deputy Director of People and Culture	Identified HR Leads and Specialisms	Performance and Goverance Meeting	People and Culture Committee
	Infection Prevention	Risks relating to the management and spread of hospital acquired infection and transmission	Executive Medical Director / Chief Nurse	Director of Infection, Prevention and Control	Identified IPC Leads and Specialisms	Infection, Prevention and Control Committee	Quality Committee
	Medical Devices	Risks relating to the safe and effective use of medical devices and whole lifecycle management	Executive Director of Integrated Care, Partnerships and Resilience	Deputy Director of Integrated Care, Partnerships and Resilience	Medical Devices Safety Officer	Medical Devices Steering Committee	Quality Committee
	Medicines Management	Risks relating to the safe and effective prescribing, dispensing and administration of medications	Executive Medical Director / Chief Nurse	Chief Pharmacist	Medicines Safety Officer	Medicines Safety and Optimisation Group	Quality Committee
	Patient Safety	Risks of harm to patients from any source within the healthcare system	Executive Medical Director	Assistant Director of Patient Safety and Clinical Effectiveness	Identified Patient Safety Leads and Specialisms	Trust Wide Quality Governance Meeting	Quality Committee
	Operational Performance	Risks the Trust may be unable to fully deliver on safe, personal and effective care in line with the requirements of the NHS Constitution, relevant legislation and Patient Charter	Chief Operating Officer	Deputy Chief Operating Officer/s	Identified Leads and Specialisms	Elective Productivity and Improvement Group	Finance and Performance Commmittee
	External	Risks originating outside the control of the Trust that have the potential to impact on its operations	Executive Directors	Deputy Directors	Assistant Directors	Sub Committees and Groups	Board

Appendix D Risk Management Process

The Trust follows a structured approach to risk management to ensure risks are suitably identified, assessed, managed, controlled and reviewed effectively. The key steps involved in the risk management process are illustrated below.

STEP 1 RISK IDENTIFICATION AND METHODOLOGY

This step involves the identification of potential threats and vulnerabilities that impact on the Trust's activities and objectives. Risks, whilst remaining diverse in nature, are identified using various methodology and data analysis. Examples of the types of proactive and reactive methodology and data analysis used are included below:

Legislation	Regulatory standards	Case law	Independent review	Public inquiry	Key consultative documents
Industry and best practice	Publications and guidance	Influence of external regulators	Organisational strategy	Key objectives	Workforce structures
Job design	Service delivery models	Training and education	Staff competency	Behavioural frameworks	Incident reporting
Incident investigation	Root causation	Lessons learned	Hazard identification checklists	Use of risk assessments	Safety alert notifications
Statistical analysis and KPI	Use of questionnaires and surveys	Focus groups	Levels of complaints	Patient experience outcomes	Liability claims
Audits and inspections	Stakeholder feedback	Scenario planning	Brainstorming sessions	External benchmarking	Financial or reputational risk

The Trust has identified its risk types which are the principal risks which arise from the nature of the Trust's operating environment, supported by a comprehensive set of risk sub types aligned to each risk type and determined using risk management identification and methodology.

STEP 2 RISK ANALYSIS AND ASSESSMENT TOOLS

This next step involves all identified risks being properly assessed in terms of their impact i.e. the likelihood and actual or potential consequence. The two primary methods used are by way of qualitative and quantitative assessment.

QUALITATIVE ASSESSMENTS

A qualitative assessment:

- Is a method of evaluating and rating a risk and is more subjective based on individual perception or judgement

- Identifies potential risks by assessing their likelihood and impact using descriptive terms such as high, medium or low and prioritises them based on these descriptors
- Is particularly used where there is a lack of data or for complex risks difficult to quantify
- Examples include the use of a colour coded system e.g. red, amber or green to represent different risk levels, a risk matrix with a likelihood and severity axis and identified terms used e.g. from being 'rare' to 'almost certain' for the likelihood and 'negligible' to 'catastrophic' for the consequence etc.

QUANTITATIVE ASSESSMENTS

A quantitative assessment:

- Is a method of calculating risk based on verified evidence and when specific data or statistical analysis is gathered
- Involves quantifying the likelihood and impact of risks using numerical values (probability and monetary), calculating each risk and prioritising it based on expected monetary value
- Is used when data is widely available and for making informed decisions

OTHER RISK ANALYSIS AND ASSESSMENT TOOLS COMMONLY USED INCLUDE:

- **Cost Benefit Analysis** weighs up the pros and cons (benefits and risks) of an action
- **SWOT Analysis** helps to understand internal and external environments
- **Needs Assessments** is a systematic process of identifying and evaluating organisational needs and gaps to help focus resource towards achieving goals more effectively
- **Business Cases and Impact Assessments** are used to plan operational disruption caused by natural disasters or other external factors and forms the basis for investment in recovery, prevention and mitigation
- **Failure Modes and Effects Analysis** is a systematic approach that identifies potential failure points and are particularly useful in clinical settings to prevent errors before they occur
- **Bowtie Analysis** involves the mapping out of a pathway so as to understand the risks better
- **Generic and Dynamic Risk Assessments** are used as the primary focus of staff and patient safety risks and hazard identification

RISK SCORING MATRIX

A risk scoring matrix:

- Is a visual risk analysis tool used to plot the likelihood and impact of risks
- Is capable of assessing a broad range of risks
- Separates those risks deemed unacceptable from those that are acceptable
- Prioritises risks and helps allocate effective use of resource by focusing on mitigating high scoring risks first.
- Provides consistent results when properly applied
- Helps communicate risk information and clear understanding of levels of risk to stakeholders
- Is relatively simple to use and can be adapted to meet specific needs

The likelihood is an estimation of risk over a stated period i.e. initial, current and target score or related to a given activity. The consequence ranges from being insignificant or minor harm to death or catastrophic.

The Trust has adopted a recognised 5 x 5 risk scoring matrix which is reflected as part of the Datix risk management system module.

More detailed guidance on how to score a risk using the risk scoring matrix is included within these appendices.

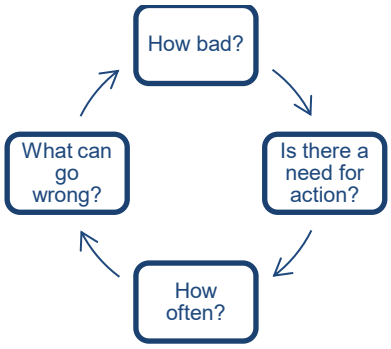
RISK ASSESSMENT SYSTEMS

Risk assessment systems are used as the primary focus of identifying, analysing and evaluating specific safety related hazards arising from the undertaking of hazardous work activities and processes. The types of hazards that present themselves follow a very structured approach and include, but are not limited to, the following:

- **Physical** e.g. building controls, fire safety, noise, electricity, vibration, ionising and non-ionising radiation, ligature points etc.
- **Mechanical / Technical** e.g. machinery, medical devices, equipment, etc.
- **Biological** e.g. blood, faeces, vomit, bacteria, viruses etc.
- **Chemical** e.g. prescribed drugs, medication errors, substances hazardous to health
- **Workplace** e.g. confined spaces, falls prevention, musculoskeletal etc.
- **Psychosocial** e.g. tiredness, distressing scenes, threats of violence and abuse, stress etc.

THE USE OF RISK ASSESSMENTS

A risk assessment seeks to look at hazards and risks and the answer to four simple, related questions



For each hazard identified, it is important to decide whether it is significant or appropriate and whether suitable controls or contingencies are in place to ensure the risk is being properly managed.

UNDERSTANDING THE DIFFERENCE BETWEEN A HAZARD AND A RISK

A medicine could be described as a hazard if there is the potential to cause harm. However, the risk of harm may be very small provided effective control measures are in place. If a patient could suffer harm from taking the medicine, the change of the harm occurring at a given severity may be described as a clinical risk. If harm resulted from taking the medicine and it was not expected this would be a patient safety incident.

It is important to identify and have a clear understanding of the significant risks of each particular hazard. Risks should be described separately and clearly e.g. when considering the hazard of selecting the wrong drug because of similar lookalike packaging, there is risk to the patient, risk to staff involved and risk to the organisation. The failure to describe or define each risk clearly may lead to potential problems when undertaking risk assessments.

GENERIC RISK ASSESSMENTS

Generic risk assessments must:

- Be conducted for all identified hazardous work activities and processes
- Be completed, at regular intervals, either through approved documentation, a recognised e-learning training package or where is not possible, by a competently trained manager or assessor, with the cooperation of staff and others, where necessary
- Consider the advice or instruction provided by other competently trained persons, medical or otherwise, that may impact on its effectiveness
- Result in the implementation of suitable control measures or interventions to eliminate or reduce risks to their lowest level practicable
- Be communicated to all relevant staff and others, where necessary, who may be affected by such work activities and processes

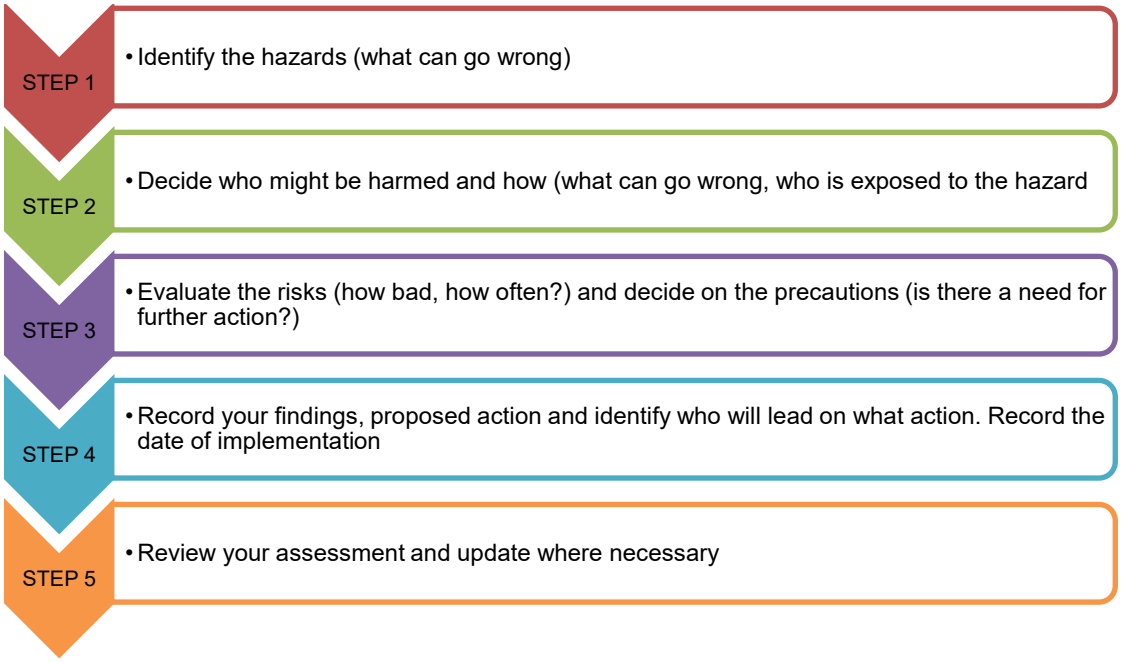
Examples of the types of generic risk assessments used include:

- Data protection
- Emergency planning
- Infection prevention and control
- Nursing assessments e.g. bedrails, catheter, falls, safer nursing care, venous thromboembolism etc.
- Pre employment checks
- Workplace health and safety assessments e.g. display screen equipment, fire safety, hazardous substances, new and expectant mothers, stress etc.

A generic risk assessment form is contained within these appendices.

STEPS TO RISK ASSESSMENT

When assessing any type of risk consideration must always be given to the following five steps shown in the diagram below.



Identify the hazards

Risk assessments should be tasked based. To prevent harm, it is important to understand not only what is likely to go wrong but also how and why it may go wrong. Consideration needs to be given to the activity within the context of using risk identification methodology and those involved in the activity.

Decide who might be harmed and how

Human behaviour shows people make mistakes and to this extent it is necessary to anticipate some degree of human error and try to prevent the error from resulting in harm.

Consideration needs to be given to the complexity of the task, numbers and types of persons affected over a stated period. This needs to include those persons who are most vulnerable and are likely to suffer harm, examples of which include:

- Those staff directly or indirectly employed such as agency or maintenance workers, contractors, cleaners, persons working in proximity nearby or passing through the work area
- Non-employees such as patients, visitors or members of the public

Some staff may be particularly of higher risk e.g. those that are young or inexperienced, new and expectant mothers, night workers, lone workers or staff with physical or mental impairments.

Evaluate the risks

This element explores the consequence i.e. how bad and the likelihood i.e. how often and whether there is a need for additional action. It involves the effectiveness of those existing controls and estimation of risk i.e. risk score and of what further preventative risk treatment actions need to be taken to eliminate or reduce the risk to its lowest level practicable to protect persons from harm.

Record your findings and proposed actions

Assessments and action plans should be recorded and changed where necessary. It is important to show that a thorough check was made to identify all the hazards and treat all significant risks, that the precautions are reasonable and remaining risk, if any, acceptable and that solutions are realistic, sustainable and effective. It is reasonable to accept some degree of preventable risk if the benefits to be gained outweigh the risk itself.

Review and update your assessment

Risk assessments should be continuously reviewed, especially where there is reason to suspect their validity. Examples of when to review assessments include situations involving:

- Changes in job design, tasks and individual capability
- Hazardous substances or equipment being used
- Introduction of staff and new technology, systems or processes
- Changes to any procedure or work processes which may need to be followed
- The health effects to individuals of any identified risks
- The findings of risk assessments, precautions, interventions and control measures
- Reported symptoms of sickness or ill health or changes in personal circumstance
- Results of any health surveillance, environmental surveys or workplace monitoring schemes

Generally, risk assessments should be reviewed when an appropriate timescale has passed, normally two or three years since the last risk assessment was undertaken.

USE OF DYNAMIC RISK ASSESSMENTS

A dynamic risk assessment:

- Is the process of identifying, measuring and evaluating risks in real time which allows staff to quickly identify hazards 'on the spot,' remove them and proceed with work safely
- Is not written down but are performance by regularly observing and analysing often high risk or changing work environments and making rapid, yet considered decisions

They are of particular importance within healthcare environments because they are widely and regularly used due to the unpredictability and constantly changing nature of risks that may arise from healthcare work activities and processes or where hazards may not be known until an event, or something happens.

Examples include the escalation of violence and abuse of a patient or member of public, having to respond to unexpected deterioration of a patient's condition or a community nurse visiting a new patient at their home etc.

The outcome of performing dynamic risk assessments can help identify, connect and visualise critical risk clusters that may be present within the workplace and clinical environments which, in turn, can help reduce accidents and injuries caused by difficult to predict hazards.

STEP 3 RISK MITIGATION

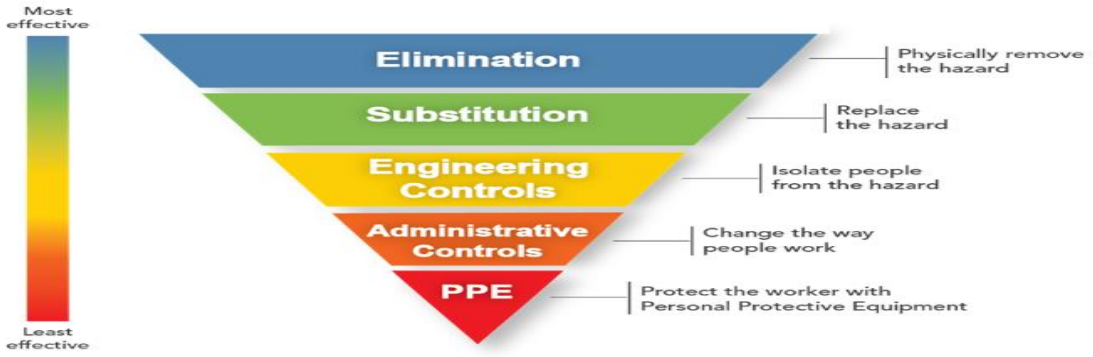
The process of risk mitigation involves:

- Developing plans that determine those risks requiring immediate attention based on significance, along with the introduction of specific controls
- Ranking of risks based on risk scores and other factors such as strategic significance, risk appetite, stakeholder concerns or legal requirements
- Prioritising actions, with focus on the most critical scoring risks
- Using a recognised hierarchy or model of risk control

- Monitoring and reporting on progress and results of risk management controls

HIERARCHY OF RISK CONTROL

The steps involved in the hierarchy of risk control are used alongside risk treatment methods and are simplified using the diagram below:



Once risks have been identified and assessed, suitable controls need to be implemented. Elimination is the most effective method however this is not always achievable. Substitution and engineering controls can significantly reduce risks along with the use of administrative controls and personal protective equipment, the latter of which is used as a last resort in maintaining safety standards.

STEP 4 RISK TREATMENT

Risk treatment is the process of taking action to manage identified risks and works alongside the hierarchy of risk control. Understanding the different types of risk treatment options and how they apply, especially within a healthcare setting, is a crucial step in the risk management framework.

There are several factors to consider when choosing the right risk treatment option. These include:

- The safety and wellbeing of patients and staff as the primary concern
- The potential impact of the risk on the Trust and its strategic goals
- The likelihood of the risk materialising
- The balance of risk treatment costs against limited resource and budgetary constraints
- The legal implications and mitigation of liability claims
- Ensuring all risk treatment options are ethically sound and do not compromise the rights of individuals
- Risk appetite statements defining the levels of risk the Trust is willing to accept, often influenced by its commitment to safety and potential impact on public trust
- A cost benefit analysis evaluating the costs of treatment against the potential benefits of risk reduction and ensuring effective use of resource
- Transparency and accountability by way of openly communicating risk management strategies and regularly reporting on the effectiveness of risk treatment options

A breakdown of risk treatment options and examples within healthcare settings is included in the table below:

Treatment	Definition	Response	Example/s
Acceptance	Acknowledging risks and deciding not to take any action by accepting the actual or potential consequence	Used for risks deemed insignificant or low or where cost of treatment outweighs benefits	Minor medical device malfunction knowing a backup is available and impact on patient safety is minimal Short delay with an outpatient appointment knowing this will not significantly impact on patient care
Avoidance	Avoiding the risk altogether or eliminating the risk entirely by discontinuing the activity or process	Used for risks with high potential impact or where consequences are unacceptable	Avoiding a high-risk surgical procedure unless absolutely necessary, opting for less invasive alternative or delaying the procedure until a patient's condition stabilises
Reduction	Reducing the likelihood and impact of the risk	Taking specific action to manage the risk	Implementing strict infection control policy and hand hygiene protocols, wearing appropriate RPE and PPE, isolating patients with infectious disease to mitigate the risk of hospital acquired infection Use of electronic medication administrative systems, implementing double checking procedures and providing training on safe medication practice to minimise medication errors Implementing falls prevention measures and educating staff on falls risk factors to reduce numbers of falls and levels of harm
Transfer	Moving risks to external parties	Transfer of risk through contracts, outsourcing or insurance	Use of liability schemes to transfer risks of legal claims arising from medical negligence Outsourcing of non-core functions to a third-party provider and transferring the risk associated with those services Entering infrastructure projects such as new hospital buildings and transferring the risk of construction and maintenance to a private provider
Diversification	Spreading risks across different areas	Dividing the risk with other parties through joint collaboration ventures	Sharing a risk of a new treatment with other healthcare organisations or research institutions through collaborative clinical trials, pooling of resources and expertise, reducing the individual risk

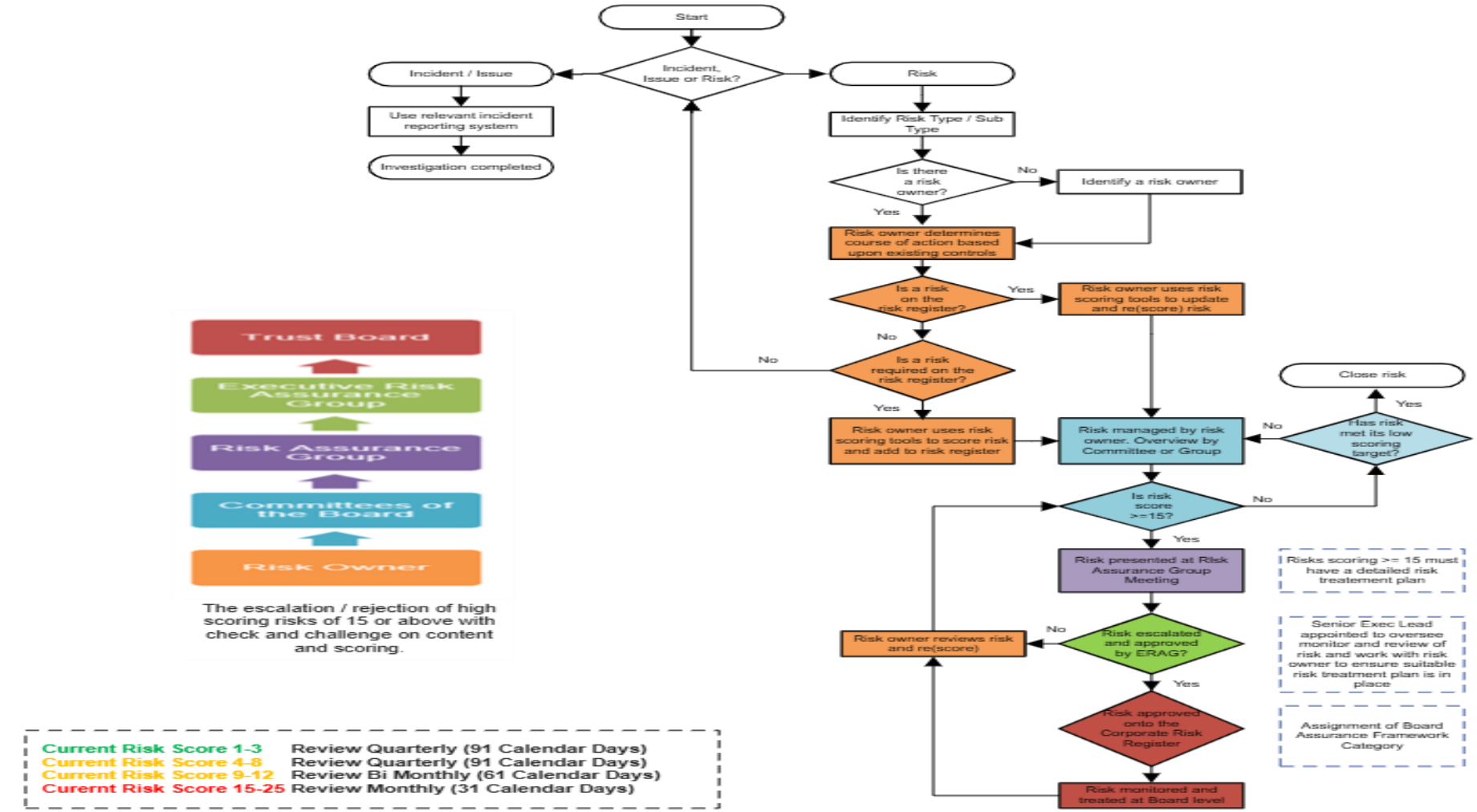
STEP 5 RISK MONITORING

The monitoring and review of risks remain critical to the success of any risk management efforts. Annual review, regular reporting, audits and evaluations help identify new and emerging risks and assess the effectiveness of internal systems of control, with regular feedback from stakeholders providing valuable insight into areas for improvement, awareness and education to ensure everyone involved is aware of the types of risks identified, how they are presented and managed, by whom and where.

With reference to the monitoring compliance section of this framework, set key performance indicators are used to measure risk management activity and track progress towards the achievement of risk management objectives through a variety of metrics that include the following:

- Risk identification and classification accuracy
- Use of generic risk assessments and frequency of review
- Reduction in numbers of open risks held on the risk register
- Reduction in numbers of catastrophic, significant or moderate scoring risks
- Review of risk cycle completion rates and numbers of open overdue risks
- Effectiveness of risk mitigation strategies and treatment plans
- Effectiveness of controls and assurances
- Reduction in numbers of risks by length of time open >3yrs
- Ratio of risks on the risk register in relation to events
- Numbers of reported accidents, incidents and near misses and level of harm
- Financial performance
- Patient and staff satisfaction
- Timeliness of risk mitigation in measuring the speed and efficiency of implementing risk controls
- Compliance with risk management policy, procedures and risk assessment processes
- Review of training needs analysis
- Effectiveness of training programmes, attendance / compliance rates and their application

Appendix E Risk (De) Escalation Process Flowchart



Appendix F Risk Appetite Statements

2025/26 Risk Appetite Statement

1. Introduction

Risk appetite is defined as the amount of risk, on a board level, that an organisation is willing to accept in pursuit of its strategic objectives. The Board of Directors has considered and documented its risk appetite statement in order to assist decision-makers across the Trust in understanding the degree of risk to which they are permitted to expose the Trust to, whilst encouraging enterprise and innovation.

The statement of risk appetite is dynamic and will be reviewed at least annually by the Board to ensure that it reflects the rapidly changing external environment within which the Trust and wider NHS operates.

2. Key context for Risk Appetite Statement 2025-26

The Trust enters 2025-26 in a difficult period where it seeks to ensure continued delivery of its vision to deliver safe, personal and effective care at a time of national and system change and within a very constrained financial position which has led to regulatory action under the NHS Oversight Framework by being placed into Segment 4/Recovery Support Programme.

Key considerations which have informed the identification of our key strategic risks are outlined below:

2.1 Quality

- Quality and safety must not be compromised and needs to continuously improve
- Improving health inequality and equity for the people of East Lancashire and Blackburn with Darwen needs to be central to our decision making
- We need to continue to engage with and involve our patients and local population in our decision making

2.2 Our People

- Improving the lived experience of our patients and staff must continue to be one of our key guiding principles
- The pressure on our workforce must be recognised in providing for patient and service needs at a time of increased demand and unrelenting need to reform how we work
- We must transform and reduce our workforce numbers to support financial recovery and recognise and recognise the impact of this on staff morale
- We must continue to support the health and wellbeing of our colleagues
- We need to develop capacity and skills for delivery of reform/change and support our colleagues to work at pace achieve this

2.3 Finance

- The Trust has a significant financial deficit and has been placed in NHS NOF 4/Recovery Support Programme. The Trust must meet its obligations of delivering the legal undertakings agreed.

2.4 System Leadership

- There are significant national and regional changes underway to NHS England, Lancashire and South Cumbria (L&SC) Integrated Care Board (ICB)
- The role of Place and Neighbourhoods is vital to support effective demand management and care closer to home
- There needs to be an effective/mature system strategy and commissioning – there are ongoing issues in terms of maturity and impact
- The L&SC Provider Collaborative continues to mature it partnership but needs to increase delivery of key programmes supported by strong governance
- The L&SC System is in deficit with other providers and the ICB being placed in NHS NOF 4/Recovery Support Programme

- There is an ongoing need to balance but recognise the tension of the Trust's duty and desire to collaborate for the benefit of our patients, Trust and system whilst ensuring organisational regulatory requirements are met

2.4 National Context

- A New NHS 10 Year plan will be published with 3 shifts at its core:
  - Moving care from hospitals to communities
  - Making better use of technology
  - Focusing on preventing sickness, not just treating it
- The ongoing impact of demand and pressure on services alongside the financial context has the potential to impact on quality at organisational, system and national level
- There continues to be a top-down performance management system approach

3. Use of the Risk Appetite Statement

The statement of risk appetite is a broad one, to be used as a tool enabling better internal control but does not offer definitive answers to any specific risk management issue. When assessing and managing risk, managers should review the risk appetite statement to help them determine an acceptable risk target score and set out the mitigating action required to achieve this.

No statement of risk appetite can encompass every eventuality and there may be exceptions where the Board has valid reasons for setting a level of tolerance outside of the scope of the risk appetite. In these cases the rationale for the Board's decision will be formally documented.

4. Risk Appetite Statement

Quality

Delivering high quality, safe, personal and effective services is the main objective of the Trust. Therefore the Trust has a **cautious** appetite for risks to the quality and safety of patient care. In practice this means that the Trust's preference is for risk avoidance. However, if necessary, the Trust will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.

Financial

The Trust's appetite with regards to its finances or use of resources is **cautious.** The Trust is prepared to accept the possibility of limited financial risk. In recognition of the Trust's need to meet its statutory duty of 'living within its means', value for money is a primary concern.

People

The Trust is committed to recruiting and retaining the best staff. It has an appetite to **pursue** workforce innovation. The Trust is willing to take risks which may have implications for the workforce but could improve the skills and capabilities of our staff. The Trust recognises that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.

Regulatory

The Trust will have a **minimal** appetite for non-compliance with regulatory requirements. It will avoid any decisions that may result in heightened regulatory challenge unless absolutely necessary.

Reputational

The Trust will **pursue** innovation even if this means taking decisions that are likely to result in the scrutiny of the organisation. It will outwardly promote new ideas and innovations where potential benefits outweigh the risks.

5. Risk Appetite Definitions and Target Scores

The risk appetite definitions have been aligned to the Trust's risk matrix.

Descriptor	Definition	Risk Target Score
None	Avoidance of risk is a key organisational objective	0
Minimal	Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	1-3
Cautious	Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential	4-6
Open	Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward	8-12
Pursue	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	15-20
Significant	Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust	25

Approved by: The Board of Directors

Date Approved: 14 May 2025

Date to be Reviewed: 14 May 2026

Appendix G Guidance on How to Score a Risk

This guidance provides risk owners with simple instructions on consequence and likelihood scoring, overall risk scoring and grading. It reaffirms the importance of a consistent and systematic approach to the management and assessment of risks and of ensuring resource is proportionate to the level of risk

The guidance outlines the model risk matrix previously described within this framework and includes tables for consequence and likelihood scoring, examples of risk domains and of calculating risk scores.

Instructions for use

1. Define the risk explicitly in terms of the adverse consequence that might arise from the risk being assessed. It is important to consider from whose perspective the risk is being assessed i.e. organisation, member of staff, patient etc. because this may affect the assessment of the risk itself, its consequence and subsequent action taken.

2. Use Table 1 below to determine the consequence score for the potential adverse outcome of relevance to the risk being evaluated. Choose the most appropriate risk domain for the identified risk using the left-hand side of the table, then work along the columns in the same row to assess and measure the severity of risk on a scale of 1 to 5 to determine a consequence score, which is the number given at the top of the column.

   The consequence should be assessed using the types of methodology and qualitative and quantitative data gathered and used during the risk identification process, together with information used in the consequence scoring criteria table, to obtain a consequence score.

3. Once a specific area of risk has been assessed and its consequence score agreed, the likelihood of that consequence occurring can be identified by using Tables 2a, b or c. When assessing the likelihood, it is important to consider those control measures already in place. The likelihood score reflects how likely it is that the adverse consequence described will occur. The likelihood is scored by considering:

   - Frequency i.e. how many times will the adverse consequence being assessed be realised or:
   - Probability i.e. what is the chance the adverse consequence will occur in each reference period

   Use Table 2a to score the likelihood by assigning a broad, predicted frequency of occurrence. If this is not possible, use Table 2b to assign a probability to the adverse outcome occurring within a given timeframe such as the lifetime of a project. If it is not possible to determine numerical probability use the other probability descriptor, Table 2c, to determine the most appropriate score.

4. Use Table 3 to calculate the overall risk score by multiplying the consequence score by the likelihood score i.e. C (consequence) x L (likelihood) = R (risk score).

5. Identify the level at which the risk needs to be managed within the Trust, assign priorities for remedial action and determine whether risks are to be accepted based on the colour bandings and risk rating and included on the risk register for de(escalation) at the appropriate level.

Table 1 Consequence Scoring Criteria

Consequence score (severity levels) and examples of descriptors

	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption **Environmental impact**	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Additional examples	Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient	Wrong drug or dosage administered with no adverse effects Physical attack such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare acquired infection (HCAI) Incorrect or inadequate information/communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long term HCAI Retained instruments/material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall resulting in injury such as dislocation/fracture/blow to the head Loss of a limb Post traumatic stress disorder Failure to follow up and administer vaccine to a baby born to a mother who has hepatitis B	Unexpected death Suicide of a patient known to the service the past 12 months Homicide committed by a mental health patient Large scale cervical screening errors Removal of wrong body part leading to death or permanent incapacity Incident leading to paralysis Incident leading to long term mental health problem Rape/serious sexual assault

Table 2a Likelihood Score (broad description of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 2b Likelihood Score (time framed descriptors of frequency)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Table 2c Likelihood Score (probability descriptors)

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Probability Will it happen or not?	<0.1 per cent	0.1 – 1 per cent	1 -1 0 per cent	10 – 50 per cent	>50 per cent

Table 3 Overall Risk Score (Consequence x Likelihood (C x L))

	Consequence (current)				
Likelihood (current)	**1 None / Insignificant**	**2 Low / Minor**	**3 Moderate**	**4 Severe / Major**	**5 Death / Catastrophic**
5 Almost certain. Will undoubtedly recur possibly frequently	5	10	15	20	25
4 Will probably recur, but is not a persistent issue	4	8	12	16	20
3 May recur occasionally	3	6	9	12	15
2 Do not expect it to happen against but it is possible	2	4	6	8	10
1 Cannot believe this will ever happen again	1	2	3	4	5

The total scores obtained from the risk matrix are assigned grades as follows:

Score	Risk level	Action required	Review
1-3	LOW	NO FURTHER ACTION but ensure controls are maintained and reviewed	Quarterly (91 calendar days)
4-8	MODERATE	MONITOR look to improve at next review or if there is significant change	Quarterly (91 calendar days)
9-12	SIGNIFICANT	ACTION make improvements within a specific timescale. Risks deemed as moderate to high require a risk treatment plan in line with risk appetite statements. Those risks where it is deemed no further treatment can reduce the risk will be regularly reviewed to assess the impact on strategic and operational objectives	Bimonthly (61 calendar days)
15-25	HIGH	URGENT ACTION take immediate action and stop activity if necessary. Risks scoring this high require a systems approach to identify root causation and help choose a suitable risk response. Where it is not possible to terminate or transfer the risk a mitigation plan needs to be out in place and monitored at senior management and board level	Monthly (31 calendar days)

Appendix H Blank Generic Risk Assessment Form

Date of assessment:			
Assessment carried out by:		**Job Title:**	
Assessment checked and approved by:		**Job Title:**	
Division:		**Department / Location**	
What is being assessed (task, activity, premises, person)?			
Review Date			

What are the hazards?	Who might be harmed and how?	What are you already doing to control the risks?	What further action do you need to take to control the risk?	Actioned moved to action plan?

ACTION PLAN				
Action No	**Action Required**	**Assigned to**	**Date to be completed by**	**Date action completed**

GUIDANCE NOTES FOR COMPLETION

Refer to the Appendix D Risk Management Process – Step 2 Risk Analysis and Assessment Tools

This blank form is recommended for use as a generic risk assessment form for activities, tasks, buildings and or environmental risks where there is no generic risk assessment form in place. Please refer to any risk assessment processes contained within existing policy and or procedures prior to its use.

Further advice and or supplementary guidance can be obtained from the Health, Safety and Risk Team

Appendix I Datix Risk Register Descriptors and User Guidance

The most common risk descriptors used when placing a risk onto the risk register are as follows:

Heading	Guide
Risk ID	A unique identifier in a numbering system assigned to a risk. The identifier should be used for reference or cross reference
Risk Title	A brief description of the risk in no more than 10 words or so
Risk Type	The category of identified risk
Risk Sub Type	A filter of the identified risk type category
Risk Handler	The owner responsible for managing the risk
Risk Lead	An executive lead or nominated person who oversees management of the risk. Acts as the risk handler in the absence of the risk handler
Additional User Access	Any other relevant person with responsibility for managing the risk, overseeing it or certain aspects of it
Opened Date	The date the risk was created and how long it has been on the risk register for
LAST review date	The date the risk and its controls and assurances were last reviewed by the risk owner
NEXT review date	The date the risk, its controls and assurances are due to be reviewed again. Review dates are in accordance with the total risk score
Risk Location	The level/s at which the risk will affect e.g. organisation wide, divisional, service etc.
Risk Description	A description of the risk event, its cause and effect. The risk should be articulated clearly and concisely. When wording the risk, it is helpful to think about it in three parts e.g. there is a risk of 'x' which is caused by 'y' and can lead to 'z' if not suitably managed or controlled
Controls	What is in place that stops or controls the risk from occurring e.g. trained staff, policies in place and actively monitored, active check lists etc.
Gaps or Weaknesses in Controls	What could be put in place to create further control measures e.g. staff have not been trained, policies are not in place, being monitored or followed, active check lists not in place or being used etc.
Assurances	What is in place to assure that controls are working e.g. training records of compliance, results of audits or inspections, monitoring reports to committees or groups, assurances from external or internal bodies etc.
Gaps or Weaknesses in Assurance	What has been identified that could be improved or put in place e.g. no training log kept that staff have been trained, negative outcomes of audits or inspections, increasing numbers of incidents, complaints, claims etc.
Risk Grading	The use of the risk matrix to provide an initial, current and target risk score
Action Plan	An action plan is easier to complete once gaps in controls and assurances have been noted. It is a risk treatment plan of how to ensure gaps become controls and assurances

RISK REGISTER USER GUIDE

The link below contains guidance on all the tools necessary to report and review a risk, as well as produce statistical and listing reports and includes the following:

- Risk register workflow overview
- Adding a new risk register record
- Adding risk gradings
- Review of a risk register record
- Adding contacts to a risk register record
- Adding actions to a risk register record
- Adding action chains to a risk register record
- Adding notes to a risk register record
- Adding progress notes to a risk register record
- Adding documents to a risk register record
- Sending email notifications
- Linking and viewing records from other modules e.g. incidents etc.
- Final review and closure of a risk
- Updating the approval status of a risk register record
- Running reports

https://datixweb-documentation.private.prod-uk.datixcloudiq.co.uk/Content/m_dx_publication_1/c_dx_riskregister_guide.htm

Further advice and guidance can be obtained from the Datix Manager

Appendix J Risk Management Training Needs Analysis

Context

Risk management is a critical component of effective healthcare delivery within the NHS. It involves identifying, assessing and mitigating potential threats and vulnerabilities that could negatively impact on the quality and delivery of healthcare service provision, patient and staff safety and organisational efficiency.

This comprehensive training needs analysis aims to ensure that relevant staff are equipped with the necessary knowledge and skills to identify, assess and manage risks effectively within their respective roles.

By understanding and implementing risk management principles staff can contribute to a safer and more efficient healthcare environment.

Legislation and Guidance

The following legislation and guidance have been used when determining training needs.

- Health and Safety at Work etc. Act 1974
- Management of Health and Safety at Work Regulations 1999
- Health and Safety (Training for Employment) Regulations 1990
- Health and Safety (Information for Employees) Regulations 1989
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Health and Safety Executive Guidance HSG 65 ‘managing for health and safety’
- Care Quality Commission ‘fundamental standards of quality and safety’

Expert Organisations

Further guidance on risk management can be obtained from the following national bodies.

- The Health and Safety Executive (HSE)
- The Care Quality Commission (CQC) England
- The Institute of Occupational Safety and Health (IOSH)
- The Institute of Risk Management (IRM)
- Health Education England

Training Objectives

Training objectives have been aligned to Risk Management Policy, Strategy and the NHS Core Competency Framework. The objectives of risk management training are to:

- Increase awareness and understanding of risk management concepts and principles
- Improve skills in risk identification, assessment, risk evaluation, and risk mitigation
- Enhance knowledge of relevant risk management regulations and standards

- Implement the risk management framework and policy
- Monitor and review risk management effectiveness
- Foster a culture of safety and proactive risk management
- Develop the ability to identify and address potential risks within specific job roles

Target Audience / Stakeholder Identification

Training will be delivered to the following groups of staff identified as having significant risk management responsibilities. These include:

- Executive Leadership i.e. Chief Executive Officer, Medical Director, Nurse Director etc.
- Clinical Leads e.g. Management, Nursing and Operational etc.
- Corporate Leads e.g. Data and Digital, Emergency Planning, Estates and Facilities, Finance, Human Resources, Infection Control, Medical Devices, Medicines Management etc.
- Quality and Safety Teams e.g. Divisional Quality and Safety Leads, Legal Services, Complaints, Patient Experience etc.
- Health, Safety and Risk Management Team.
- Datix Manager.
- Patient Safety Specialists and Investigators.
- Administrative Staff i.e. Governance and or Compliance Officers etc.
- Training and Development Teams.
- Patient Advocacy Groups, where appropriate.

Key Learning Outcomes

The following key learning outcomes reflect the minimum standard required. At the end of the session the learner will be able to:

- Define risk and its significance in healthcare
- Identify potential threats and risks within a healthcare setting
- Assess the likelihood and impact of identified risks
- Develop effective risk mitigation strategies
- Implement risk management practices within daily work activities
- Contribute to a culture of risk awareness and proactive risk management

Where appropriate, additional learning outcomes and practical experience will be supplemented by specific job and onsite training and consider the capabilities, knowledge, skills and experience of staff, as well as any prior training.

Training Content

The training content is designed to address training objectives and learning outcomes and incorporates the following elements:

- Risk management fundamentals i.e. definitions, importance and benefits, key principles, types of risks, risk management process, strategy and framework

- Risk identification and methodology i.e. methods for identifying potential threats and vulnerabilities that could impact on patient and staff safety, service quality and organisational efficiency and the effective use of risk registers

- Risk analysis tools i.e. type of qualitative and quantitative analysis tools commonly used, risk scoring matrix, the probability and impact of risks

- Incident management i.e. requirements for reporting, investigating and learning from incidents

- Risk assessment i.e. five steps to risk assessment, use of generic risk assessment templates and dynamic risk assessments within healthcare

- Risk mitigation strategies i.e. prioritisation and treatment of risks, developing action plans and effective risk control measures

- Monitoring and review i.e. tools and methodologies to review and improve risk management practices continuously

- Risk communication skills i.e. the ability to effectively communicate risk related information to patients, staff and other stakeholders

- Risk governance i.e. maintaining a robust risk management strategy and framework, roles and responsibilities of staff groups, use of committees, sub-committees and or working groups

- Regulatory compliance i.e. overviews of relevant legislation and set regulatory standards

- Ethical considerations i.e. implications for risk management in maintaining ethical standards in patient care

- Case studies. Real world examples of risk management challenges and solutions

- Interactive exercises. Role playing, simulations and or group discussions

Training Methodology

A blended learning approach will be employed to cater to diverse learning styles and maximise engagement. This includes:

- Online modules. Self-paced learning modules will provide foundational knowledge on risk management concepts, principles and tools

- Classroom and workshops. Interactive sessions will offer hands on experience in risk identification, assessment and mitigation techniques. Case studies and group discussions will help foster critical thinking and problem-solving skills

- On the job training. Opportunities for on-the-job training and shadowing will allow staff to apply learned concepts to their specific roles and responsibilities

- Mentoring and Coaching. Experienced professionals will provide guidance and support to new learners, promoting knowledge sharing and continuous development

- Simulation exercises. Role playing scenarios that mimic real situations

- Webinars and seminars. Professionally led discussions on current threats, opportunities and best practice in risk management

Required Frequency of Refresher Training or Assessment

Refresher Period

- Current legislation does not mandate defined time schedules for refresher periods. General consensus and best practice indicate risk management training should take place every two to three years or whenever there is reason to suspect its validity and effectiveness

Organisational Implication

- The required training schedule is required to be incorporated into risk management policy and procedure along with a programme of monitoring key performance metrics in place

- The outcomes and implications of audits should be used to ensure key policy and procedural arrangements remain robust, are being monitored and implemented appropriately and inform training priorities

- Refresher training will be indicated for all relevant staff should there be a change in legislation or set regulatory standards, where new risks have been identified, if there is a change in working practices and procedures or where knowledge and skills need updating

Evaluation and Feedback

The following evaluation methods will be used to assess the effectiveness of training:

- Pre and post training assessment to measure changes in the acquisition of knowledge and development of skills

- Feedback surveys that collect participant feedback and seek insight on the descriptive content, relevance, effectiveness, delivery and areas for improvement

- Observation and application of risk management principles in daily work

- Organisational outcomes. Assessment of the impact of training on risk management outcomes and performance metrics to track changes in incident reporting rates, improved risk management compliance and overall safety improvements

- Longitudinal studies that evaluate sustained changes in staff behaviour, organisational culture and performance over time

Ongoing Development

To help drive a culture of continuous risk management improvement:

- Regular updates will be made to training materials that reflect changes in legislation, set regulatory standards, best practice, emerging risks and feedback

- Provision of ongoing support and resources will be made available to staff to maintain and enhance professional development opportunities and risk management skills

- Risk management principles will be embedded into organisational safety related strategies and culture

Training Needs Assessment Framework

The following framework has been employed to identify knowledge and skills gaps, assess and determine training needs and requirements:

- Surveys and Questionnaires. The use of quantitative data to gather intelligence regarding current knowledge levels, skills and perceived training needs

- Interviews. The use of informal interviews and discussions with key stakeholders and representatives across various corporate and clinical roles to gain insight into their experiences with risk management, understand specific challenges and identify specific requirements

- Focus Groups. Facilitating discussions amongst corporate and clinical teams to identify challenges and training interests

- General Observations. Observing staff in their daily work settings to assess risk management practices and identify areas for improvement

- Identify Skills Gaps. Identify specific areas where relevant staff may lack the necessary skills to effectively manage risks within their areas of responsibility and control such as risk assessment, risk mitigation and incident reporting

- Documentation. Review and analysis of strategy, policy and procedures, risk identification methodologies and risk analysis tools used, and incident management to identify common risk related issues and training opportunities

- Regulatory Compliance. Assessment of compliance with relevant risk management legislation and set regulatory standards e.g. HSE and CQC etc

- Incident Management. Determine the effectiveness of incident reporting and analysis processes for identifying and addressing risk factors

- Risk Culture. Assessing the existing risk culture and identifying barriers to effective risk management

Assessment of Competence

Where a relevant member of staff or learner can demonstrate through robust pre-assessment, the required level of current knowledge, understanding and practice, this can be used as evidence that knowledge and skills have been maintained and that the member of staff may not need to repeat refresher training.

Should a member of staff or learner not meet the required level of knowledge, understanding and practice through pre-assessment, they should complete refresher training, and any other associated training or assessments required.

Standards for Training Delivery

The Trust musty be assured that learning facilitators involved in the delivery of any education or training sessions relating to risk management possess the appropriate qualifications, knowledge, skills and experience to deliver training to a satisfactory standard. This may include:

- A relevant qualification in health and safety and or risk management

- A current and thorough knowledge of health and safety, including risk assessment and management and an understanding of its application and practice within a healthcare setting

- Knowledge and experience of risk management within the organisation

- Experience of teaching and learning, including the ability to meet the competencies expected and to plan and prepare specific learning and development opportunities

- Membership of a relevant professional body

Where the delivery of training is supported by a person who is not an expert in the subject, the Trust should ensure they have put in place a quality assurance mechanism whereby the accuracy of the content and effectiveness of its delivery has been quality assurance checked and subject to periodic observation and review.

Appendix K - Definitions

The following terms are used within this framework

Term	Definition
Accident	A type of incident which is separate, identifiable, unintended and causes physical injury
Act(s)	Enacted piece of primary legislation, commonly called law, which are general in nature and issued by Parliament
Approved Codes of Practice and Guidance	Guidance on the best practical means of compliance with the requirements of an Act or Regulation
Approving / Ratifying Committee	A committee responsible for approving and or ratifying strategies and policies. All policies need to be approved and sent for ratification. This information is normally within the Policy Standard or Policy Schedule
Assets	Any resource or valuable item an organisation possesses. These assets are tangible or intangible and essential for an organisation's operations and success e.g. physical, human, information, reputational, financial and technical value
Assurance	Confidence provided to stakeholders that risks are being managed effectively through oversight and controls
Board Assurance Framework	A high level, structured document summarising key risks, controls and assurances to help Boards manage strategic objectives
Care Quality Commission	Independent regulator of health and social care services in England, whether provided by the NHS, local authority, private companies or voluntary organisations
Committee	For the purpose of this framework, the term 'Committee' refers to the East Lancashire Hospitals NHS Trust Board, its Committees, Sub Committees and Groups.
Competence	A person who has demonstrated ability to effectively apply knowledge, skills and capabilities to successfully perform a specific task, role or function within a given context, meeting established standards of performance
Consequence	The impact or effect of a risk event, often scored to assess severity
Controls	Measures such as systems and processes implemented to eliminate or reduce the likelihood or consequence of risks
Corporate Governance	A holistic approach to developing systems of internal control within an organisation and the verification of the effectiveness of these systems
Corporate Risk Register	A register of high scoring risks that present a significant threat to the strategic and operational objectives of the Trust, approved and escalated for board level monitoring and review of risk action or treatment plans, linked to the Board Assurance Framework
Crisis Management	The strategic response to the immediate aftermath of a major incident
Current Risk	The level of risk remaining after existing controls have been applied
Document	For the purpose of this framework, a document refers to a strategy, policy, procedure or guidance note
East Lancashire Hospitals NHS Trust	A large integrated healthcare organisation providing acute secondary healthcare for the people of East Lancashire and Blackburn with Darwen, in the heart of the Northwest of England
Equality Impact Assessment Tool	A legal requirement under race, disability and gender equality legislation, it is a systematic and evidence-based tool that considers the likely impact of implementation on different groups of people
Exposure	The extent to which an organisation is vulnerable to a specific risk or cumulative risks

Guidance	Issued by regulatory agencies or professional bodies with the aim of providing supportive information on what is good practice. It does not contain any specific reference to legislation as with an Approved Code of Practice
Hazard	A threat, natural or human, which has the potential to cause harm
Hazard Identification	The process by which hazards are determined or spotted
Health and Safety Executive	Government agency responsible for the encouragement, regulation and enforcement of workplace health, safety and wellbeing and for research into occupational risks in England, Wales and Scotland
Incident	A near miss event that whilst not causing harm has the potential to cause injury or ill health and includes a set of conditions or undesired circumstances that have the potential to cause injury or ill health
Inherent Risk	The level of risk before any controls or mitigations are applied
Likelihood	The probability of risk occurrence
Loss	Any negative i.e. financial, operation or otherwise etc. impact of a risk
Mitigation	A strategy that eliminates or reduces risk by lowering the likelihood of a risk event occurring or reducing the impact of the risk should it occur
NHS Resolution	An organisation that handles liability and negligence claims and works to improve risk management practices within the NHS
Objective	A goal that an organisation aims to achieve
Opportunity	A positive outcome or benefit arising from uncertainty
Overall Risk Score	A combined measure of the likelihood and consequence used to prioritise risks
Policy	Plan of action adopted and a principle by which all staff are guided and directed in pursuit of corporate objectives. It is a formal document which must be followed by relevant staff. Non-compliance may leave the organisation and staff open to unacceptable risk A policy formally documents an approved standard or process and may be relied upon for legal purposes
Principle Risks	Risks that impact on the achievement of strategic objectives recorded on the Board Assurance Framework
Procedural Document	Within the context of this framework, a procedural document is a procedure that is laid down in writing that supports the implementation of a policy
Procedure(s)	A particular way to accomplish an objective by a sequence of activities or course of action (with definite start and end points) that must be followed correctly to perform a task
Regulation(s)	An enacted piece(s) of secondary legislation, also referred to as a statutory instrument, enforced by the Health and Safety Executive that are more specific in nature and support the ethos of Acts
Risk	The likelihood and severity of harm arising from a hazard
Risk Appetite	The amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives
Risk Assessment	The overall process of risk analysis and evaluation
Risk Tolerance	The boundaries within which senior executive leaders are willing to allow the true day to day risk profile of an organisation to fluctuate, while they are executing strategic objectives in accordance with the Boards strategy and risk appetite
Risk Exception(s)	A decision to accept higher than usual levels of risk due to specific circumstances and or risks escalated through governance frameworks
Risk Category	Grouping of risk types based on shared characteristics and denominators e.g. clinical, financial etc.
Risk Management Framework	A structured approach for identifying, assessing, mitigating, monitoring and communicating risks

Risk Management	A planned and systematic process for identifying, assessing, managing, controlling and reviewing risks and mitigating those unacceptable risks to minimise harm, improve safety and performance
Risk Owner	The responsible point of contact for an identified risk, who coordinates efforts to mitigate and manage risks and its suitable monitoring and recording on the risk register
Risk Register	A log of risks that threatens an organisation's success in achieving its declared aims and objectives. It is a dynamic living document, populated through an organisations risk profiling, assessment and evaluation process. It enables risks to be quantified and ranked, providing a structure for collating information about risks
Stakeholder	Person or groups of persons with an interest in the activities of an organisation
Strategy	A statement of where an organisation wants to be in the future, often defined by its strategic objectives
Target Risk	The desired level of risk after planned mitigation measures have been implemented
Treatment	Strategies or actions taken to address identified risks e.g. avoidance, acceptance, transfer etc.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Quality Committee	**Report to:**	Trust Board
Date of Meeting:	26 November 2025	**Date of next meeting:**	17 December 2025
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This report delivers a summary of the items discussed at the Quality Committee meeting held on 26 November 2025.

Alert

What	So What	What Next

1. The committee received the ELHT Annual Complaints Report, summarising the Trust's activity and performance in managing concerns and complaints through the Customer Relations Team from April 2024 to March 2025.	• The committee heard that the Trust continues to receive a proportionate number of complaints for its size, demographic and specialties against other comparable Trusts, based on NHSE data.
	• The report outline key themes of complaints ad concerns over the period of patient care, clinical treatment (particularly ED, general medicine and obstetrics/gynaecology), waiting times and staff attitude.
	• The committee were concerned about the timeliness of responses to complaints and concerns, notably:
	  ○ An average of 71 days to respond against a target of 25 - 40 working days.
	  ○ 88% of responses exceeding the required timeframe for response since agreed standards were
		• The committee requested a formal update on the quality improvement work underway, and its impact on timeliness of response.

	introduced where a formal response was required. o An average of 50 days to respond to level 2 concerns, against a target of 10 working days. • The committee heard that quality improvement work around the timeliness of complaint responses is underway.	
Assurance		
What	**So What**	**What Next**
1. The Committee received a number of documents relating to Health and Safety within the Trust: a. Quarterly Health & Safety Update b. Annual Health & Safety Report c. Trust Health & Safety Strategy	• The reports presented demonstrated a significant improvement in terms of a strengthening of governance, audit response, performance and training as well as highlighting an overall improvement in meeting statutory obligations and a strengthening safety culture. • The reports highlighted the strategic priorities for 2025-26 and outlined the key concerns relating to Health & Safety. • There was a request of the committee to approve targeted investment in IOSH-accredited training, strategic alignment and resources needed to deliver expected legislative and regulatory requirements. This request was recognised, however the committee chair was unable to agree to the request and asked for additional information on the quantum of investment needed. There was additional a recognition that the Health & Safety Strategy would need to be approved by the Trust Board,	• Further information will be presented to the committee to provide a clearer view of any required investment needs, with referral to other appropriate committees as required. • The full Health & Safety Strategy will be presented to the committee and to Trust Board at a date to be confirmed.

2. The committee received a report outlining that the Burnley Hospital Surgical Hub had been recognised as an accredited elective surgical hub for adults and paediatrics by the national GIRFT team.	• The surgical hub at Burnley hospital was visited and inspected by the GIRFT team in September 2025. • The team were impressed with the professionalism and enthusiasm of the staff. • This is a significant achievement for the Trust and reflects the hard work of the team. • GIRFT accreditation provides a nationally recognised quality mark for the surgical hub. • A number of opportunities for further improvement were recognised and an action plan is being developed to address these.	• The committee will continue to receive updates on the progress of the action plan relating to improvement opportunities.
Advise		
What	**So What**	**What Next**

1. The committee received an update paper on the work of the Holistic End of Life Decision-Making (HELD)Collaborative.	• HELD (Holistic End of Life Decision-making) is an ELHT improvement collaborative designed to strengthen recognition of dying and ensure timely, person-centred Do Not Attempt Cardio- Pulmonary Resuscitation (DNACPR) decisions.
	• The committee heard that the project had established strong foundation, namely:
	  ○ A dedicated Project Faculty is in place
	  ○ Workstreams have been initiated for Complaints and IT/Documentation
	  ○ A Trustwide DNACPR audit has been completed with analysis underway
	  ○ A local staff survey is currently live
	  ○ Engagement across clinical teams continues to grow
	• The committee heard that whilst engagement was improving, medical representation was not yet widespread across all areas.
		• The committee has requested an update paper to be delivered which address the key identified risks for the collaborative.

	• The committee heard that clarity was required regarding the governance for DNACPR and ownership of the associated policy.	
2. The committee received a draft of the ELHT All Age Mental Health Strategy 2025-28	• The presentation outlined the key drivers for the strategy, the identified key commitments which will provide the focus for the roll out. • The committee recognised the work which had been undertaken to produce the strategy and agreed that the identified key commitments were appropriate. • The committee asked for additional detail relating to how the strategy would be put into operation, particularly around identified education for staff and any associated financial impact of the roll-out of the strategy.	• A further paper will be presented to the committee providing the additional information requested.
3. The committee received the monthly update on the actions undertaken following the HTA Inspection of mortuary services in April 2025.	• The paper outlined the progress made against a number of key areas of the Corrective and Preventative Action (CAPA) Plan, notably recruitment of an additional anatomical pathology technologist, key improvements in staff training and competency assessments, the development of a Mortuary Improvement Board which would commence meeting in early December 2025 and a visit by the Coroner in November 2025, with positive feedback. • The committee noted the significant work that was being undertaken to address the concerns	• The committee will receive ongoing monthly updates on the progress of the CAPA actions.

	raised by the HTA and requested that the CAPA should be annotated to provide clearer timelines for completion as well as being RAG-rated for ease of reference	
4. The committee received a comprehensive report summarising the Trust's commitment to embedding health equity into its core mission.	• The report outlined that there is a recognition that our communities still experience significant disparities in outcomes, access and experience, influenced by deprivation, ethnicity, geography and broader social factors. • The Trust has developed a comprehensive approach to health equity that aligns with national frameworks such as Core20PLUS5, the NHS Long-Term Plan, and the Equality Act 2010, as well as Integrated Care Board priorities. The approach is also underpinned by recognised public health models and guided by leadership, inclusion, collaboration, and accountability. • The paper outlined progress to date, including the establishment of a Health Equity Committee which will focus on maturing governance mechanisms, establishing equity dashboards, embedding patient leadership and maximising the Trust's role as an anchor institution. • The paper identified key areas of concern, including: o Persistent health inequalities across conditions. o Lifestyle and behavioural risk factors. o Life expectancy gap.	• The committee will receive updates on the work of the Health Equity Committee and provide feedback to the Trust Board.

	○ Incomplete or inconsistent data. ○ Systemic and organisational barriers. ○ Pressure on limited resources.	

Other agenda items

- Internal audit review management action plan clinical coding.
- Integrated performance report.
- ELHT UEC Reset
- Mental health patient demand and financial impact to the Trust.
- Winter Plan 2025-26
- Nurse staffing exception report
- Quality assurance assessment framework update
- PSIRF report

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Quality Committee	**Report to:**	Trust Board
Date of Meeting:	17 December 2025	**Date of next meeting:**	28 January 2026
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This report delivers a summary of the items discussed at the Quality Committee meeting held on 17 December 2025. The meeting was a reduced-agenda meeting, recognising that is coincided with industrial action by Resident Doctors.

Alert

What	So What	What Next
1. There were no items for immediate escalation to the Trust Board at the December 2025 meeting.	•	1

Assurance

What	So What	What Next
1. The committee received a review of neonatal mortality, which compared ELHT to other Neonatal Intensive Care Units (NICUs) in the network in terms of birthrate and mortality from 2017 – 2023. The paper also compared ELHT with the other NICUs across the country.	• The committee heard that ELHT had the highest number of births among the 5 NICUs in the network. The neonatal mortality rate for ELHT was 1.64 which was 5-15% below the group average and showed a decreasing trend. • The committee heard that the mortality rate (excluding congenital abnormalities) of 1.24 was still 5-15% below the group average when all level 3 NICUs in the UK were included. • Extended perinatal mortality (neonatal. Mortality plus stillbirths) were 5-15% below the network NICUs, with a similar performance of 5-15% below the rest of the country's NICUs.	• The team were congratulated on the work they had undertaken in terms of the provision of assurance and on the structures and process in place to monitor neonatal mortality. • The team were commended for the decrease in mortality rates. • The team were encouraged to continue their improvement work and challenged to become a national exemplar unit. The Medical Director will work with the service to help drive these improvements and the committee will receive ongoing feedback.

	• The committee heard that there was similar positive performance when analysis of more recent data was reviewed. • It was demonstrated to the committee that neonatal mortality is on the decline in ELHT when compared to the national and network trends, that a robust mortality review and governance process is in place ad that all learning and action points are followed through, with assurance provided. • It was recognised that there was still scope for improvement in mortality associated with extreme prematurity and work is ongoing to address this.	
Advise		
What	**So What**	**What Next**

1. The committee received a highlight report for the Urgent and Emergency Care (UEC) Reset Programme, March to Success	• The report focused on alleviating pressure across the UEC system, with a particular focus on areas during the Winter period.
	• The committee heard that there was focus on improvements in internal processes and outcomes as well as work with wider system colleagues to reduce demand in UEC.
	• Key internal work remains focused on:
	  ○ Ambulance Hospital handover
	  ○ Time to be seen in the Emergency Department
	  ○ Earlier input by the acute physician
	  ○ Medical and Emergency Care Division discharge focus
		• The committee will receive ongoing report relating to UEC.
		• The committee recognised the ongoing challenges in UEC and the significant work that was being undertaken to address these challenges.
		• The committee stressed the need to hold system-wide colleagues to account for their role in reducing acute demand in UEC.

	○ Step up and expansion of Virtual Ward utilisation. • The Out of Hospital programme, led by place-based partner focuses on: ○ The work of integrated neighbourhood teams. ○ Increased community engagement around strengthening advanced care planning. ○ Community health services transformation ○ VCFSE commissioning to align with new models of care. • The committee heard that the out of hospital programme initial impacts include: ○ 8% reduction in >65s UEC attendances (103 fewer per month) ○ 27% reduction in >65s emergency admissions (133 fewer per month) ○ 38% increase in advanced care plans ○ 19% increase in people dying in their preferred place.	
2. The Committee received a monthly update on progress against the HTA Inspection actions.	• The committee received assurance that good progress was being made against all actions in the Corrective and Preventative Action (CAPA) Plan, with key milestones already reached, and all outstanding items having clear dates for completion. • The committee was informed that there remains a key issue with freezer capacity for	• The Committee will continue to receive monthly updates on progress against the CAPA. Any actions with a financial implication outside current budget will be referred to the relevant committee.

	the long-term storage of bodies, but that this was being addressed. • The committee heard that a dashboard is in development to monitor mortuary service performance, which will be presented to the committee once completed. • The committee heard that a Mortuary Improvement Board meets biweekly, with membership including Coroner's Office Manager and Police representation. • The committee were informed that the national request to remove SDEC data from mortality data submissions was being reversed, with Trusts now being requested to include SDEC data in future mortality data submissions. • This change will lead to a reduction in the reliability of mortality data being received by the organisation, but will bring the Trust into alignment with the majority of Trusts across the country.	
3. The Committee received an update paper relating to the development of the Single Pathology Service across Lancashire and South Cumbria.	• The update paper provided assurance that the quality, safety and regulatory standards of pathology services across Lancashire and South Cumbria (LSC) are being maintained through the transition to a single service model. • The committee were informed of the key risks inherent in the project, namely around Governance; Workforce and the potential for industrial action; Estates; Finance and Digital.	• The committee will receive an update paper in February 2026 following the completion of workshops outlined in the December update paper.

4. The committee received a verbal update on mortality ratio data (SHMI and HSMR).	• The committee were asked to note the progress across quality and governance sub-domains ahead of further detail to be shared upon completion of workshops, and to support the structures in place relating to Equality and Quality Impact Assessments.	• The committee will continue to monitor Trust mortality data through existing processes via the Mortality Steering Group.
Other agenda items • Integrated performance Report • Patient Safety Incident Response Framework Report		

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Group:	Finance & Performance	**Report to:**	Board of Directors
Date of Meeting:	24 November 2025	**Date of next meeting:**	22 December 2025
Chair:	Liz Sedgley	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Financial Recovery M7 and WRP	WRP off trajectory due to under delivery. Deficit increasing and cash position tight. Forecast out turn gap now at £15.4m Some concern regarding OneLSC WRP delivery for y/e Divisional WRPs behind plan.	Exec to review mitigations, underperforming WRp schemes and accelerating WRP for Q4.
Assurance		
What	**So What**	**What Next**
BAF – OneLSC transition to lead provider	Committee recommended that OneLSC progress be tracked by AC due to risks	To be monitored by AC
IPR	Committee recommended escalation to People & Culture following an increase in bullying & harassment trends. Quantification of industrial action costs to be validated at next F&P	
Annual Planning	Progress noted & tight timelines.	Detail being worked up for Dec F&P and Main Board meeting in Dec.
Corporate Risk Register	Report received.	
Advise		
What	**So What**	**What Next**
Albion Mill update	Options being finalised.	Follow up at next FP

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Group:	Finance & Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	22 December 2025	**Date of next meeting:**	26 January 2026
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Finance Report M8, Financial Recovery	M8 deficit is £3.16m off plan – similar to M7. YTD deficit position increased to £46.9m and £13.4m behind plan. WRP under delivery remains the significant factor – particularly non-pay. WTE headcount increased by 81WTE – explained but needs to decrease in M9 an and M10	PMO and exec to complete WRP reprofiling and FOT mitigations asap.
Cash position	Will become challenging in M10 and revenue support PDC applied for. Significant increase in creditors from M7>M8 – challenging for suppliers. No deficit support funding (DSF for Nov & Dec).	Report outcome at next meeting.
Year End FOT and reprofiled WRP	Work underway on finalising mitigations and detail presented on likely FOT based on M8 = £48.2m deficit at y/e **Committee notes good progress on WRP mitigations/planning + Grip & Control work at the PMO but has an overall view of insufficient assurance in the detail presented at this stage that Q4 can deliver the target WRP. Significant risk remains to "most likely" FOT.**	PMO and exec to present deliverable WRP, additional mitigations and difficult decisions discussions at 10 Dec main board at next FP. Alongside to focus on additional WRP opportunities that will deliver in 26/27.
Assurance		
What	**So What**	**What Next**
Budget Setting & Planning updates for 26/27	Updates received. Final board assurance statement submitted as part of 16 Dec submission received.	Final submission in Feb – to be discussed at next FP.

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Advise		
What	**So What**	**What Next**
Pathology Update	Noted further updates for main board in Jan 26.	

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Group:	People and Culture Committee	**Report to:**	Board of Directors
Date of Meeting:	01.12.2025	**Date of next meeting:**	02.02.2026
Chair:	Liz Sedgley	**Parent Committee:**	Board of Directors

Alert

What	So What	What Next
The staff story was from 2 colleagues detailing their experiences of racism at ELHT which included pay disparity, barriers to promotion and training opportunities, lack of appreciation for their skills and work experience and racism from colleagues and patient.	4 key priorities have been identified by the staff networks as being key areas to target to address what should be recognised as systemic racism with ELHT and the wider NHS .	A paper will come back to the committee and then to Board detailing the programme of work required to deliver the priorities.
The committee was alerted to the issues with HR capacity to deal with cases around disciplinary matters, reasonable adjustments and redeployment.		
The CPO report highlighted the risk to both ELHT and the wider care sector around changes in the new Immigration Act with regards to minimum salary levels for both new and renewals of both Health and care worker visas and skilled worker visas.		
WTE reduction as at month 7 was 451.94 WTE this is still 44.29 WTE behind plan, work is ongoing by the divisions to identify a further 81 WTE reductions in 25/26 to help bridge the gap in the financial plan.		

Assurance

What	So What	What Next
A deep dive into the progress with the Commercial Income cross cutting workstream was received detailing the outcomes of 2 workshops to generate opportunities for 26/27.		
A specific HR risk management education session was held, which was well attended and there is a plan to review and address a large number of historical HR risks which are recorded on the CRR.		
The committee received, as part of the update on the work programmes to reduce sickness absence rate, a schedule showing the		

targeted sickness rates to the end of the financial year and the key milestones.		
Advise		
What	**So What**	**What Next**
The Appraisal rapid improvement week planned for December has been rescheduled to January/ February due to organisational pressures and availability of the improvement team.		
An update on the staff survey which has now closed was received, the overall response rate was 40.3% which is 2% lower than the national average. Staff feedback from those choosing not to complete the survey was that they did not see action being taken on the ground and there are still concerns from staff groups around confidentiality.		
A paper was presented on the findings from the internal audit review into the job planning process, the overall assurance opinion was limited with a number of recommendations being made. The committee heard the management responses and plans to address the gaps in process and weaknesses. A verbal update was also given on the progress of the 25/26 Job Planning cycle and also the progress of the e rostering project, the delivery of both are critical to giving the organisation sufficient data to have a complete and transparent view of job plans, performance and accountability.		

Triple AAA Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Group:	Audit Committee	**Report to:**	Board of Directors
Date of Meeting:	19th Nov 2025	**Date of next meeting:**	30th January 2026
Chair:	Khalil Rehman	**Parent Committee:**	Board of Directors

Alert		
What	**So What**	**What Next**
Internal Audit	Due to a number of factors including absences of executive leads, the IA plan for 25/26 remains **significantly off trajectory.**	MIAA continuing to progress – AC Chair to move Jan 26 AC meeting to allow IA reports with Jan deadlines to have additional time to complete.
Grip & Control Plan	Progress made since Oct IAG but limited to primarily planning & identification of G&C delivery. Noted timelines on recommendations remained on track. However, committee received limited evidencing of impact and triangulation with WRP mitigations and considered there were risks remaining for G&C to substantively continue to contribute to the FOT. In addition the Trust risks over reliance on G&C with insufficient understanding of its impact and embedding within the organisation to mitigate any potential in month pressures on the run rate. **Overall - Limited Assurance.**	To review at next AC meeting. Requested PMO continue further work and evidencing.
Assurance		
What	**So What**	**What Next**
N/A	N/A	N/A
Advise		
What	**So What**	**What Next**
OneLSC transition to Lead provider	Progress noted and further milestones in Jan 26.	Follow up reports at future committees.

Committee Escalation Report

East Lancashire Hospitals NHS Trust
A University Teaching Trust

Name of Committee:	Trust Charitable Funds Committee Report	**Report to:**	Trust Board
Date of Meeting:	18 December 2025	**Date of next meeting:**	19 January 2026
Chair:	Simon Featherstone	**Quorate: (Y/N)**	Y

Introduction

This report delivers a summary of the items discussed at the Trust Charitable Funds Comittee meeting held on 18 December 2025. This was a single agenda item meeting to present the ELHT&Me Annual Report and Accounts for 2024-25 and to make a recommendation to the Trust Board, as Corporate Trustee, to approve the 2024-25 ELHT&Me Annual Report and Accounts for submission to the Charity Commission by 31 January 2026.

Alert

What	So What	What Next
1. The committee received the ELHT&Me Audited Annual Report and Accounts for 2024-25	• The committee reviewed the audited annual report and accounts for 2024-25 and received the independent examiner's report to the Trustees of ELHT&Me for the year ending March 2025. • The committee were asked to review the reports and make a recommendation to the Trust Board, as Corporate Trustee, to approve the 2024-25 ELHT&Me Annual Report and Accounts for submission to the Charity Commission. • The committee are happy to make this recommendation to make this recommendation to Trust Board, as Corporate Trustees. • The committee recognised the impressive amount of work undertaken by the charity over this period and commended the work of key individuals.	• The Trust Board, as Corporate Trustees are asked to approve the 2024-25 ELHT&Me Annual Report and Accounts for submission to the Charity Commission. • The deadline for submission to the Charity Commission is 31 January 2026.

	• The committee recognised the work undertaken by the outgoing Chair of the committee, who stepped down from their role in December 2025.	
Assurance		
What	**So What**	**What Next**
1.	•	
Advise		
What	**So What**	**What Next**
1.	•	1.
Other agenda items No other agenda items were presented at the committee.		